Draft Quarterly Progress Report No.8
Quarter Four, FY 2011-2012
July—September 2012

This report was made possible through support provided by the United States Agency for International Development (USAID) and represents Quarterly Progress Report for the period of July, 2012 through September, 2012

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List of Abbreviation

ADD : *Alokasi Dana Desa*
AMTSL : Active Management Third Stage Labor
ANC : Ante Natal Care
APBK : *Anggaran Pendapatan dan Belanja Kabupaten/Kota*
Bappeda : *Badan Perencanaan Pembangunan Daerah*
BEONC : Basic Emergency Obstetric and Neonatal Care
BKPG : *Bantuan Keuangan Peumakmu Gampong*
BOK : *Bantuan Operasional Kesehatan*
CCM : Community Case Management
CEONC : Comprehensive Emergency Obstetric and Neonatal Care
C-IMCI : Community Integrated Management of Childhood Illness
CKMC : Community Kangaroo Mother Care
DHO : District Health Office
Dirjen : *Direktur Jenderal*
Ditjen : *Direktorat Jenderal*
DTPS : District Team Problem Solving
ER : Emergency Room
FY : Fiscal Year
GoI : Government of Indonesia
HIV/AIDS : Human Immunodeficiency Virus/ Acquired Immunodeficiency Syndrome
HWWS : Hand Washing With Soap
IBI : *Ikatan Bidan Indonesia*
IMCI : Integrated Management of Childhood Illness
IP : Infection Prevention
IPNC : Integrated Post Natal Care
JHPIEGO : John Hopkins Program for International Education in Ginecology and Obstetrics
JNPK : *Jaringan Nasional Pelatihan Klinik*
JSI : John Snow Inc.
KF : *Kunjungan Nifas* (Postpartum Visit)
KIA : *Kesehatan Ibu dan Anak*
KIBBLA : *Kesehatan Ibu Bayi Baru Lahir dan Anak Balita*
KMC : Kangaroo Mother Care
KN : *Kunjungan Neonatal* (Neonatal Visit)
LAMAT : Local Area Monitoring and Trace
LBW : Low Birth Weight
M&E : Monitoring and Evaluation
MAWG : Multi Agency Working Group
MCH-LAM : Maternal Neonatal Care-Local Area Monitoring
MDGs : Millennium Development Goals
MgSO4 : Magnesium Sulfate
MNCH : Maternal Neonatal Child Health
MNH : Maternal and Neonatal Health
MoH : Ministry of Health
MoU : Memorandum of Understanding
MPA : Maternal Perinatal Audit
MPS : Making Pregnancy Saver
MSG : Mother Support Group
MSS : Minimum Services Standard
MU : Mini University

OJM : On the Job Mentoring
P2KS : *Pusat Pelatihan Klinik Sekunder*
P2PL : *Pencegahan Penyakit dan Penyehatan Lingkungan*
P4K : *Program Perencanaan Persalinan dan Pencegahan Komplikasi*
PE/E : Pre-Eclampsia/ Eclampsia
Perbup : *Peraturan Bupati*
Perda : *Peraturan Daerah*
PHO : Provincial Health Office
PNC : Post Natal Care
PoA : Plan of Action
Polindes : *Pos Bersalin Desa*
POMA : *Pelayanan Obstetri Maternal dan Perinatal*
PONED : *Pelayanan Obstetri Neonatal Emergensi Dasar*
PONEK : *Pelayanan Obstetri Neonatal Emergensi Komprehensif*
Posyandu : *Pos Pelayanan Terpadu*
PPNI : *Persatuan Perawat Nasional Indonesia*
PTP : *Perencanaan Tingkat Puskesmas*
Puskesmas : *Pusat Kesehatan Masyarakat*
PWS-KIA : *Pemantauan Wilayah Setempat- Kesehatan Ibu dan Anak*
QA/QI : Quality Assurance/ Quality Improvement
RS : *Rumah Sakit*
RSUD : *Rumah Sakit Umum Daerah*
SBA : Skilled Birth Attendant
SBM-R : Standard Based Management and Recognition
SC : Save the Children
STIKES : *Sekolah Tinggi Ilmu Kesehatan*
TBA : Traditional Birth Attendant
TOT : Training of Trainer
USAID : United States Agency for International Development
USG : Ultrasonography
VHC : Village Health Community

MCHIP OVERVIEW

Background

The Maternal and Child Health Integrated Program (MCHIP) in Indonesia is a USAID-funded, three year program from January 2010 to December 2012, with a budget level of USD 9.8 million. This program is being implemented by Jhpiego, in collaboration with Save the Children (SC) and John Snow Inc. (JSI). In support of the MOH Road Map to the 2015 MDGs, MCHIP/Indonesia is being implemented in three districts that are classified as "Health Problem Areas": Serang District in Banten Province; Kutai Timur District in East Kalimantan Province; and Bireuen District in Aceh Province. All districts have areas that are considered "remote".

In April 2011, the program work plan was revised to accommodate scaling up of life-saving interventions throughout the 3 target provinces. This quarterly report reflects the addition of a sub-objective aimed at taking interventions to scale at the provincial level.

The overall objective of the program is to catalyze implementation of existing policies that promote key **evidence based life- saving interventions at scale** in remote areas. To achieve the program goals, MCHIP inputs are contributing to four sub-objectives:

1. Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces.
2. Improve maternal and newborn care in the community
3. Improve quality of clinical services at all levels of care
4. Improve management of district health system

Sub Objective 1(cross cutting): Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces

Results:

- District teams in three remote areas scaling up high impact interventions district-wide
- Provincial teams in three remote areas implementing plans to scale up high impact interventions in other districts, using technical assistance from core districts.

Sub Objective 2: Improve Maternal and Newborn Care Practices at the Community Level

Results:

- Expanded use of life saving approaches (postnatal care, KMC, C-IMCI) by village midwives and kaders
- Increased knowledge, skills and practices of healthy maternal and neonatal behaviors in the home
- Communities mobilized for action and advocacy

Sub Objective 3: Improve Quality of Clinical Services at all Levels of Care

Results:

- Improved competencies of health care providers for pregnancy, childbirth and postnatal care, including AMTSL, PE/E, newborn resuscitation, and KMC
- Improved systems for assuring quality of care, including the use of performance standards and maternal-perinatal audit

Sub Objective 4: Improve Management of the District Health System

Results:

- Increased use of evidence-based planning at all levels of the health system
- Improved use of LAMAT and MPA to monitor district programs and achievements
- Institutionalized support and resources for maternal, neonatal and child health

MAJOR ACCOMPLISHMENT

- MCHIP in this quarter focused primarily on replication assistance in the district and the province. Following the Mini University, all 42 participating districts selected programs for replication, 34 of whom participated in the Training of facilitator for at least one program intervention, and 20 of whom requested and received technical assistance from the MCHIP districts to implement at least one of the programs.
- The compentency of midwives in the three target districts are at 100% for AMTSL, an increase from the previous quarter.
- Following the approval of Qanun KIBBL in Bereuen, 62 pending Perdes ensuring local commitment toward MNCH was approved.
- At the national level, flipcharts for *Kelas ibu*, and guidelines for IPNC and C-IMCI were drafted and piloted for nationwide use and distribution.
- The number of births in the six MCHIP puskesmas in Kutai Timur increased significantly in this quarter, with close to 80% of the births attended by SBA in the MCHIP puskesmas area now happening at the puskesmas.
- The program learning design for the MCHIP handover at the central level was finalized. MCHIP plans to provide feedback to the MoH on facilitating program roll out in provinces and districts.

NARRATIVE DESCRIPTION

Sub-objective 1: Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces

a. MDG Road map

The GoI in 2010 through a presidential decree (*no.3 Th 2010*) required all provinces and districts to accelerate the achievement toward the MDGs during the next five years. As a part of this initiative "MDG Roadmap" a strategy document at the national level was developed and distributed throughout Indonesia for replication at the provincial and the district level. The "MDG Roadmap" outlines goals, activities, timeline, indicators, and targets to measure progress toward the MDGs. MCHIP facilitated the finalization of the MDG Roadmaps for Bireuen and Serang for health, specifically MDGs 4 & 5 for submission to the District and Provincial Bappeda.

For Kutai Timur, the finalization process is ongoing and is scheduled for October 2012 by the Bappeda. Series of meetings with the DHO, District Planning board, and multistakeholders, to reach consensus on the Roadmap was conducted in Kutai Timur. The Kutai Timur local government has committed to using the MDGs roadmap as a reference for budget planning in sectoral department (SKPD/Satuan Kerja Perangkat Daerah) and also for mid-term development plan (RPJMD/Rencana Pembangunan Jangka Menengah Daerah).

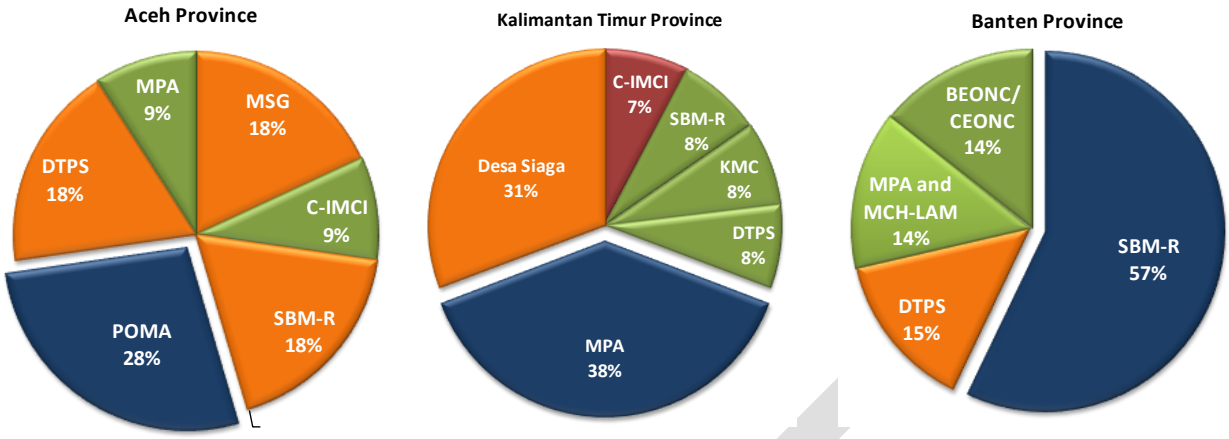
The "MDG roadmap" finalization is a priority for the MCHIP close-out sessions. While MCHIP supports MDGs 4 & 5, the finalization of other MDGs targets by other sectors remains a cause of delay for the finalization of the entire MDG's Road Map.

b. *Replication Post Mini-university.*

MCHIP defines replication as the facilitation of technical assistance from the MCHIP districts to the other districts and subdistricts for adoption of the national MNH programs. The replication steps and progress toward each is defined below.

i. **Program Selection** One of the goals of the Mini-University was to receive commitment from the participating districts to implement similar MNH programs in their districts. The participating districts selected the MNH programs they intend to implement using the following criteria 1) district need; 2) availability of Human Resources; and 3) the availability of budget. The districts also felt that if the program was deemed necessary, funds could be requested for the implementation of the program in the district planning and budget cycle. POMA was selected as the first priority program for replication in Aceh, Maternal perinatal audit in Kalimantan Timur, and SBM-R in Banten.

Fig 1. First Priority Program Selected for Replication in the 3 Provinces



ii. **Resources for Replication.** MCHIP has developed the following resources to support replication. These resources will be socialized to the MoH during the close out meetings.

- Detailed program and cost guidelines
- Detailed guideline to develop an integrated MNH program
- Facilitators and champions for replication of integrated MNCH program at the provincial, district, and village level

iii. **The Process of Replication**. The table below describes the design for replication, participant in each step, and the funding source for each step. The budget is being cost-shared, primarily coming from DHO/PHO reflecting onwnership and support for the program.

Fig 2. Replication Process for the three Provinces

No	Activity	Participants	Trainer/ conducted by	Budget	
				MCHIP	DHO/PHO
Step 1	**Orientation** on MNCH Integrated Program	Facilitators from MCHIP districts	PHO, MCHIP	✓	
Step 2	**Training of Facilitator** for selected program at province level	Facilitators from replication districts in 3 provinces	Facilitators received Orientation	✓	✓
Step 3	**Training for Puskesmas and village** facilitator at district level	Facilitators from Puskesmas and Village level	Facilitators from each replication district that received training of facilitator.	✓	✓
Step 4	**Program implementation**	N/A	Implemeting district		✓
Step 5	**Monitoring and evaluation at district level**	N/A	PHO, DHO, & MCHIP (time permitting)	✓	✓

The table below summarizes the replication progress to date. Key points are:

- All 42 participating districts selected programs for replication after the Mini University.
- A total of 34 out of 42 districts participated in the Training of facilitator for at least one program intervention. Primary reason cited for dropping off was the lack of budget in the district.
- MPA and DTPS were the most requested for replication. These choices were driven by the need to understand why and where the maternal and newborn deaths were happening and influence the allocation of appropriate resources.
- Of the 34 districts that participated in the training of facilitators, 20 districts further requested and received technical assistance from the MCHIP districts to implement at least one of the programs.

Figure 3. Summary of Replication Achievement in 3 Provinces

No	Variable	Aceh	Kalimantan Timur	Banten
1	Total districts in province (not including MCHIP district)	**22**	**13**	**7**
2	Number of districts that signed up for replication	**22**	**13**	**7**
3	Number of districts that participated in the orientation	**22**	**13**	**7**
4	Number of districts that completed Training of facilitator	**68%** 15 out of 22 districts	**92%** 12 out of 13 districts	**100%** 7 out of 7 districts
5	Number of districts that requested and received TA from MCHIP district for replication	**30%** 5 out of 15 that completed step 4	**66%** 8 out of 12 that completed step 4	**100%** 7 out of 7 that completed step 4
5	Districts that received the highest number of technical Assistance for replication	**Pidie** MTBS-M, SBM-R, POMA, DTPS	**Balikpapan** AMP, DTPS **Penajam Paser Utara** Desa Siaga, SBM-R	**Tangerang, Lebak, Pandeglang, Kota Tangerang, Kota Serang, Kota Tangsel** 2 programs each
6	Number of districts that is planning to replicate their first priority program selected at the Mini University	**68%** 15 out of 22 selected as first priority	**85%** 11 out of 13 selected as first priority	**100%** 7 out of 7 selected first priority

8	The most in the process of being replicated	**MPA** Selected by 6 districts	**MPA** Selected by 7 districts	**DTPS** Selected by 7 districts
9	Total Subdistricts and Puskesmas in MCHIP district	**12 Subdistrict** (total 18 Puskesmas)	**13 Subdistrict** (19 Puskesmas)	**25 Subdistrict** (30 Puskesmas)
10	Sub-district that received technical assistance from MCHIP for replication	**100%** 12 out of 12 Puskesmas replicate IPNC, Kelas Ibu, LAMAT, C-IMCI, SBM-R, MPA	**100 %** 13 out of 13 subdistricts replicate Kelas Ibu (13 Puskesmas in Aug 2012) And 2 subdistricts Desa Siaga & Midwife-TBA partnership (Muara Ancalong and Muara Bengkal replicate after Mini University)	**100%** 30 out of 30 Puskesmas replicate SBM-R 7 out of 7 subdistricts replicate Kelas Ibu and and Midwife-TBA partnership

Step 1 Orientation. The purpose was to build the capacity of the facilitators from the MCHIP districts and the province to develop an integrated MNH program. The orientation was conducted by MCHIP and PHO. The orientation addressed the development, implementation, and sustainability, of integrated MNH program (KIBBLA Terpadu).

MCHIP in coordination with PHO and DHO developed a guideline to document the lesson learned, best practices, and steps to develop MNCH Integrated Program at district level. The guideline describes four components for KIBBLA Terpadu as translated from MCHIP Indonesia that facilitators ought to know. The four components are:

Fig 4. Book Cover of Integrated MNCH Program

- **What is "KIBBLA Terpadu"?**
  MCHIP defines KIBBLA Terpadu as integrated Community, Clinical, and Management system to support continuum of care. Planning, implementation, problem solving, and evaluation for all MNH programs should be synergized to represent integrated MNH programs.
- **How KIBBLA Terpadu works?** First *shared vision* to make every one understand why KIBBLA terpadu is important in their area of work. Second, identify *leaders* to champion KIBBLA. Third is the *collaboration* among all stakeholders at all levels.
- **How to implement KIBBLA Terpadu?** First, *orientation* for stakeholders where shared vision should be hihlighted and awareness of MNH issues raised.Second, *technical guidance* for program implementation and Monitoring and evaluation. Third, *consistent advocacy* to the stakeholders and the decision makers.
- **How to maintain and sustain the KIBBLA terpadu?** In the short-term advocacy and coordination with the National Planning board or Bappeda is essential. In the long-term perbup or perda should be advocated to the executive and legislative stakeholders

MCHIP also developed a website for KIBBLA terpadu - www.kibblaterpadu.net and all materials from the Mini Universities from the 3 provinces was uploaded to this website, and a discussion forum is available for all districts for replication of the KIBBLA Terpadu. All participants of the Mini U will be able to access KIBBLA Terpadu information from this website. Socialization of the KIBBLA Terpadu was conducted in July in 3 Provinces for DHO, Puskesmas, and Hospital staff.

Fig 5. The 3 in 4 MNCH Integrated Program Implementation

Step 2 Training of facilitators. After the completion of the Mini University, a letter from the Provincial Health Office with the Mini University implementation summary report and list of program that was selected for replication by the district was sent to the participating districts. The letter informed the districts to re-register for Training of Facilitator with mandatory cost-share for participants' cost.

The Training of Facilitator was conducted at the province and district level. Not all of the districts that had signed up for replication at the Mini University, attended the training of facilitators - the primary reason cited were budget limitation at the district level.

Fig 6 dr.Atahillah SpOG, a facilitator from Dr.Fauziah Hospital facilitating MPA Training of

In Banten all of the districts that selected program for replication continued with the training of facilitator for at least one program. In Kalimantan Timur 12 out of 13, and in Bireuen 15 out of 22 continued with the training of facilitator. Each district sent 2-5 participants on average from DHO, Bappeda, Hospital, and related stakeholders depending on the training topic. In Kalimantan Timur districts cost-share from private sector Coorporate Social Responsibility funded some of the participants.

The training of facilitator in each province was led by the team of facilitator from the MCHIP districts who also presented at the Mini University. The facilitator is from the DHO, Puskesmas, and the hospital. These facilitators will serve as resources for continuation and expansion of integrated MNH programs in the province.

Fig 7. Number of Mini University Facilitators in 3 Provinces

Aceh Province	Kalimantan Timur Province	Banten Province
• DTPS : 8 facilitators • SBM-R : 7 facilitators • Kelas Ibu : 4 facilitators • MTBS-M : 5 facilitators • POMA : 4 facilitators • AMP : 5 facilitators	• AMP : 6 facilitators • DTPS : 7 facilitators • Desa Siaga : 16 facilitators • SBM-R : 3 facilitators • IP : 2 facilitators • C-IMCI : 10 facilitators	• PONEK : 8 facilitators • SBM-R : 4 facilitators • Kelas Ibu : 5 facilitators • PWS-KIA & AMP : 6 facilitators • DTPS : 4 facilitators • MNERC : 12 facilitators • PONED : 5 facilitators

Following the Training of Facilitator, District Health Office sent letter to the participating districts summarizing the report of each training of facilitator event with a list of Plan of Action for each program to be implemented and offering technical assistance to districts from July through September.

Step 3. Technical Assistance for replication

Following the Training of Facilitator at the Province level, some districts requested technical assistance from MCHIP district for program implementation in their area.

In Aceh, the DHO from Pidie requested technical assistance for the implementation of the SBM-R, three local facilitators from Bireuen conducted SBM-R workshop in Pidie. The budget for this activity came from the implementing districts and PHO. The workshop participants were 6 puskesmas, 2 districts hospital, and Pidie DHO. As a follow on, the participants from each puskesmas and hospital drafted their action plan for SBM-R in their work place.

In addition to SBM-R, the Aceh facilitator also provided technical assistances for other programs including:

- DTPS for Aceh Tamiang district
- POMA program for Aceh Barat dan Aceh Jaya
- Kelas Ibu for Aceh Tengah
- MTBS-M for Aceh Tengah.

In Kalimantan Timur, the facilitators from Kutai Timur provided technical assistance for MPA program to Kutai Kartanegara (on June 23-24 with 61 participants) and Bontang (June 27 with 34 participants). This activity was funded by the implementing districts and CSR from the private companies and a plan of action was generated to implement MPA at the district. Other districts that requested technical assistance were:

- Bulungan, Tarakan, and Nunukan district for kader Desa Siaga workshop
- Balikpapan district for DTPS
- Penajam district for SBM-R
- Tana Tidung and Balikpapan for MPA

In Banten technical assistance was provided to all 7 districts on topics ranging from SBM-R, Infection Prevention, PWS-KIA, MPA, and BEONC/CEONC programs. The technical

assistance in Banten is immediately followed by training of facilitator that was conducted in the same period. The budget for this activity was from the implementing districts and MCHIP.

Fig 8. Further Technical Assistance for Districts

No	Technical Assistant	Districts
Aceh Province		
1	SBM-R	Pidie and Langsa
2	MTBSM	Aceh Tengah
3	Kelas Ibu	Sabang, Gayo Luwes, Aceh Tengah
4	POMA	Aceh Barat and Aceh Jaya
5	DTPS	Aceh Tamiang
Kalimantan Timur Province		
1	Desa Siaga	Bulungan, Tarakan, Nunukan
2	DTPS	Balikpapan
3	SBM-R	Penajam Paser Utara
4	MPA	Tana Tidung, Balikpapan
Banten Province		
1	SBM-R	7 districts in Banten Province
2	PWS-KIA	7 districts in Banten Province
3	MPA	7 districts in Banten Province
4	BEONC/CEONC	7 districts in Banten Province

Based on above table, it shows that technical assistance in Banten has been provided to all districts, facilitated by easy access between districts, low cost, small number of districts and readiness of facilitators. While in the other two districts distance, access, large number of districts, budget, and limited sensitization of the facilitatros and providers were some constraints. For example P2KP or the institution for clinical training is not active in Bireuen and Kutai Timur, so clinical trainers were invited from the closest district, Sigli, and Samarinda.

Replication at the Sub-District Level Within MCHIP District

MCHIP facilitated the strengthening of the existing programs to all the non-MCHIP subdistricts in the 3 districts. In Bireuen, 12 out of 12 non-MCHIP Puskesmas received support for IPNC, Kelas Ibu, LAMAT, C-IMCI, SBM-R, and MPA. Some were provided before Mini University, showing the enthusiasm of DHO to implement the program by requesting technical assistance from MCHIP. In Kutai Timur, MCHIP facilitated *Kelas Ibu* in 12 out of 12 non-MCHIP subdistricts in August 2011. Additional technical assistance to the Muara Ancalong and Muara Bengkal subdistricts for Desa Siaga and Midwife-TBA partnership was conducted in September 2012. While in Serang, 25 out of 25 non-MCHIP Puskesmas received technical assistance for the SBM-R program after mini university.

Sub-objective 2: Improve Maternal and Newborn Care Practices in the Community

a. Mother's classes (Kelas Ibu).

Kelas Ibu is Mother's classes at the village level where pregnant women and mothers are given key messages on maternal and newborn areas including nutrition/ anemia, exclusive breastfeeding, immunization, skilled birth attendant, newborn and maternal danger signs, hand washing, and family planning.

MCHIP has facilitated 238 Kelas ibu across 170 villages in the three MCHIP districts. Out of the 238 Kelas ibu, around 50% (104) is now funded by the puskesmas using the budget (*BOK-Bantuan Operasional Kesehatan)* or the community budget ADD.

Replication of *kelas ibu* completed in majority of MCHIP districts beyond the MCHIP target subdistricts.

Fig 9. Number of *kelas ibu* in the target and replication sites.

	Bireuen	Kutai Timur	Serang	Total
Number of *Kelas ibu*	62	42	134	**238**
Number of target Villages	62	42	66	**170**
Number of *kelas ibu* that will receive funding from village and Puskesmas after MCHIP	62 *kelas ibu* funded by community (not ADD) (MCHIP only supports for stationeries)	31 *kelas ibu* funded by village (ADD) 11 *kelas ibu* funded by community (MCHIP no longer support *kelas ibu*)	Funding not available yet, still in process to get the BOK budget for Kelas Ibu	**104**
Replication within MCHIP district	12 out of 12 sub-districts	12 out of 13 sub-districts. (Wahau sub-district not replicate)	7 out of 25 sub-districts in Serang that overlap with EMAS area (65 *kelas ibu* within 65 target villages)	**31 sub-districts**
Replication in non MCHIP districts (**Training of Facilitator**)	Replicated in 5 districts (Gayo Luwes, Aceh Tamiang, Aceh Tengah, Bener Meriah, Sabang)	Replicated in 3 districts (Bulungan, Nunukan, Tarakan)	NA Only replicate at subdistrict level.	**8 districts**
Replication in other districts (**Further technical**	Technical assistant to 4 districts using district budget	Technical assistant to Bulungan district as a package of	NA Only replicate at subdistrict level.	**5**

assistance to districts)	for Aceh Tamiang, Gayo Luwes, Aceh Tengah, Bener Meriah.	Desa Siaga replication		

In this quarter, beyond the ongoing implementation and monitoring of *kelas ibu,* and the replication effort post mini-university, Bireuen had a series of discussion with the 6 Puskesmas to review the performance of *kelas ibu* in their respective areas. Participants attendance, facilitator competency, support from the village, and the intended behavior change amongst the community was discussed as the objective of *Kelas Ibu*.Changing Kaders, new village midwives, and budget constraints were some of the challenges cited. Increases in positive health practices such as the exclusive and immediate breastfeeding, delivery in facility and postnatal visit were also observed. The findings will inform the larger feedback on *Kelas ibu* to the MoH.

At the national level: The national *kelas ibu* flipcharts that was updated with the MCHIP experience was pilot tested in all three districts. The findings informed the changes in the content and the design. For example, adhering to the Jampersal guideline, and advocating for the newly married women to attend. The flipcharts once finalized will be printed and distributed.

Challenges and lesson learnt to date

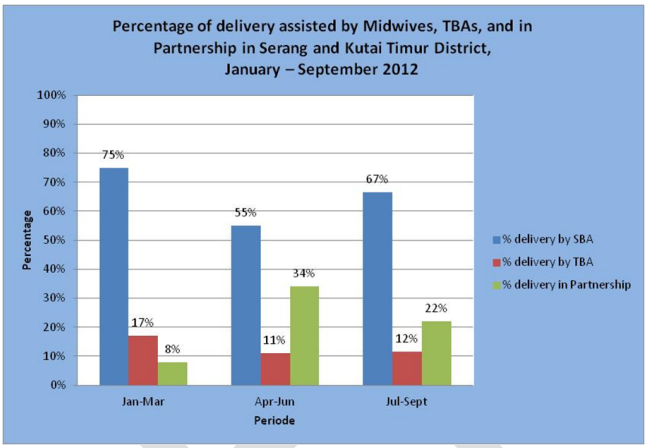
The challenges and lessons learnt on *Kelas ibu* to date are:

a) There are differences in commitment amongst *Puskesmas* to allocate budget for *Kelas Ibu* using BOK budget.
b) The capacity of *Kaders* in facilitating *Kelas Ibu* is different among the villages and unique between one *Kader* to other.
c) There is an emphasis from MOH that Village Midwife is responsible for *Kelas Ibu* implementation with limitated *Kader* involvement, while *Kelas Ibu* support by MCHIP uses Kader as facilitator. This was changed with MCHIP supporting the update of the *kelas ibu* flipchart.
d) The success of *Kelas Ibu* depends on facilitator (*Kader*), support from *Puskesmas* and village leaders, as well as timing and place of activity.

b. Midwife-TBA partnerships

The Partnership between Midwife and TBA builds consensus on their role during childbirth with Midwife doing the delivery and the TBA supporting the midwife and comforting the mother and the newborn. TBAs are also encouraged to connect pregnant women to midwives for delivery. To date, 89% of TBAs (256 of 287 TBA) in Serang, and 85% of TBAs (58 of 68 TBA) in Kutai Timur are part of the partnership.

Fig 10. Delivery Assistance in Serang and Kutai Timur, January-September 2012



The goal of the partnership is to increase skilled birth attendance. The data from January through September for the two districts show an increase in the percentage of births attended in partnership from 8% to 22%, and decline in birth by TBAs only from 17 to 12%. The Midwifery TBA partnership should be expanded further to target the births by TBAs only.

Challenges and Lessons learned to date

Challenges and Lessons learned to date on the Midwifery TBA partnership program are as follows:

a) The roles of subdistrict and village leaders are important in achieving the partnerhip and compliance by both midwife and TBA.
b) The success of partnership depends as much on the compliance of midwife to the partnership as compliance by the TBA.

c. *C-IMCI and community KMC (C-KMC)*

Indonesia has a national IMCI program. MCHIP introduced the community component to the IMCI program. The C-IMCI program in Kutai Timur and Bireuen developed the capacity of the health providers and Kaders to identify and treat common serious newborn and childhood infections (newborn sepsis, pneumonia, diarrhea and malaria) in the community with limited access to facility-based care. MCHIP packaged the community based Kanagaroo mother care (C-KMC) with the C-IMCI program.

At the national level, MCHIP through the Multi-Agency working group provided input to the development of the C-IMCI guideline that was tested in Berau East Kalimantan in July. Berau also plans to replicate the C-IMCI program. The C-IMCI and CKMC ToF was completed in September 2012 with support from the Corporate Social Responsibility (CSR) fund and MCHIP.

i. Health workers and supervisors trained

To date C-IMCI/C-KMC has been implemented in total 113 - 72 villages in Bireuen and 41 villages in Kutai Timur. The table below shows the total number of target villages and people trained on C-IMCI in Bireuen and Kutai Timur as per Septemebr 2012.

Fig 11. C-IMCI puskesmas, area/villages and trained midwife in Kutai Timur for newborn and under five, January to September 2012

No	Puskesmas	C-IMCI Area / Village (Target)	Additional C-IMCI Area/Village	Trained Health Worker		Trained Cadres		Supervisors
				C-IMCI Newborn	C-IMCI Under 5	C-IMCI Newborn	C-IMCI Under 5	
Bireuen	Gandapura	10	2	12	12	0	0	4
	Makmur	10	3	10	10	0	0	3
	Peusangan Selatan	10	2	12	12	0	0	3
	Juli	10	0	10	10	0	0	3
	Jeumpa	10	0	8	8	0	0	2
	Peudada	12	3	14	14	0	0	2
	TOTAL	**62**	**10**	**66**	**66**	**0**	**0**	**17**
Kutai Timur	Teluk Pandan	6	0	8	8	7	6	2
	Rantau Pulung	8	0	3	8	8	8	2
	Bengalon	6	0	5	5	7	6	2
	Kaliorang	7	0	7	7	7	7	2
	Sangkulirang	6	0	7	6	6	6	2
	Kaubun	8	0	10	8	6	6	2
	TOTAL	**41**	**0**	**40**	**42**	**41**	**39**	**12**

ii. Supervision system up and running

The bidan coordinators supervise the village midwives and kaders- a monthly meeting at the puskesmas and a meeting at the village every three months. Supervision in Bireuen and Kutai Timur for C-IMCI and C-KMC programs was not functioning optimally. MCHIP has facilitated intensive supportive supervision training in both districts- while the supportive supervisions are now happening in both sites, gaps remain. For example, the capacity of the staff at the DHO responsible for C-IMCI and C-KMC for program monitoring is low, MCHIP plans to provide intensive support to the DHO staff in November.

iii. Case findings and reporting and recording

Data recording and reporting for C-IMCI and C-KMC has improved over the last two quarter. C-IMCI workers (village midwives) report any case finding of newborn sepsis and LBW into a register. By the end of each month, register will be submitted to supervisors in Puskesmas level who will then compile the case findng into monthly summary.

Data to date shows that case findings are increasing and mutual referral systems between hospitals, the District Health Office, health centers, and communities in MCHIP areas has been established. The importance of quality data and analysis was further strengthened through a C-IMCI supervisor meeting (on August 2012 and September 2012) to integrate the C-IMCI and C-KMC data into existing recording and reporting system such as, LB1 (Puskesmas monthly reporting), LAM-MCH and SP2TP, So in the next reporting period, C-IMCI data will be inserted into the Puskesmas IMCI reporting.

Fig 12. Case finding and treatment for Newborn in Bireuen and Kutai Timur Districts, January to September 2012

Bireuen District

	Low Birth Weight	Possibility of Severe Bacterial Infection	Local Bacterial Infection	Total
Live births				384
Case identified	16	7	19	42 (11%)
Case referred	0	3	0	3 (7%)
Case treated in the community	16	4	19	39 (93%)
Case recovered during this period	16	7	19	42

Kutai Timur District

	Low Birth Weight	Possibility of Severe Bacterial Infection	Local Bacterial Infection	Total
Live births				979
Case identified	59	12	114	185 (19%)
Case referred	7	6	0	13 (7%)
Case treated in the community	52	6	114	172 (93%)
Case recovered during this period	59	12	114	174

Fig 13. Case finding and treatment for the under 5 in Bireuen and Kutai Timur Districts, January to September 2012

	Pneumonia	Diarrhea	Dysentery	Fever	Total case identified	Total case treated
Bireuen	**50**	**129**	**15**	**91**	**285**	**285**
Kutai Timur	**78**	**151**	**17**	**3**	**249**	**249**

Challenges and lessons learned

MCHIP identified following challenges and lessons learnt to date:

a) Gaps in supervision is attributed to the distance and limited budget for transportation to conduct the supervision visit and issues of accessibility during rainy season. In Kutai Timur according to the DHO budgets have been allocated for supervisory visit, MCHIP facilitated refreshers and skills reinforcement sessions of the supervisors.
b) For strengthening of supervision and sustainability, MCHIP will provide intensive support to the DHO staff responsible for the C-IMCI and C-KMC. The purpose is to strengthen the skill of the DHO staff for monitoring and program analysis.
c) Since C-IMCI has a separate reporting and recording system, data on C-IMCI on the birth, postnatal visit, case findings and treatment was difficult to obtain. MCHIP in the districts collaborated with the stakeholders to include the indicators for C-IMCI and C-KMC as a part of the existing reporting and recording system such as LAM-MCH and SP2TP.

d. Handwashing for newborn survival

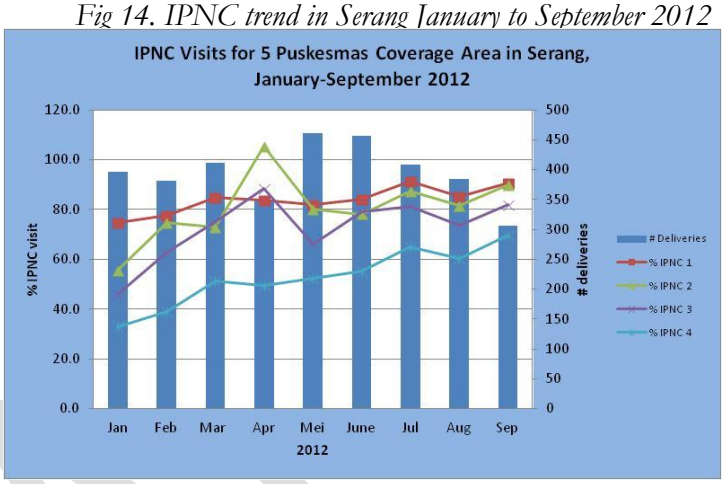
At the global level, MCHIP and Unilever formed an alliance on Hand washing with soap (HWWS) for newborn survival to increase the practice of HWWS of mothers, caregivers and birth attendants as an effort to prevent and control infectious diseases. MCHIP in the next quarter plans to socialize and disseminate HWWS for newborn survival in the MCHIP

districts through cascade training. The adaptation of the HWWS for newborn flipcharts and training materials to the Indonesian context was funded by the MCHIP global and Unilever.

e. Integrated Postnatalcare

MCHIP in Indonesia is developing an integrated model for Post natal care (IPNC) to be scaled up at the national level. The current PNC schedule for skilled care differs for the mother and the newborn, and few postnatal visits are happening at all. The period during which mothers and newborns are most at risk, 24 to 48 hours after birth, is often missed, as this early visit is not integrated into community health services.

Fig 14. IPNC trend in Serang January to September 2012



In the MCHIP districts, the midwives were trained and supervised to provide integrated postpartum visits for mothers and newborns at 6-48 hours, 3-7 days, 8-28 days, and 36-42 days. Data from all three districts show that the IPNC visits are now happening. Data from Serang shows that the majority of births from January to September received IPNC, prior to MCHIP only few postnatal visits were happening.

At the national level, MCHIP adapted the global IPNC guidelines to the Indonesia context. Series of meetings were held with the MoH at the national level to finalize the IPNC guideline. Job aids for midwives are also part of the guideline. In finalization of the guideline, MCHIP gathered input from the 3 districts, especially from the hospital staff.

Fig 15. IPNC Job Aids

Challenges and Lesson Learned:

a) In Serang, IPNC forms are available and completed by the midwife on a monthly basis. While in Kutai Timur and Bireuen, the DHO did not agree to introduce a separate form for IPNC, data on IPNC is derived from the regular PWS-KIA reports.

b) Village midwife, Puskesmas and DHO still do double reporting on Postpartum care for mother and newborn, one form is the IPNC form from MCHIP, and the other is Neonatal Visit (KN) form and Postpartum Visit (KF) form from MoH. Currently, up to national level Postpartum data is still reported using the MoH form which is seperate for mothers and newborns. This issue will be highlighted at the national level close out meeting with the DHO.

Community Activities at National Level

MCHIP coordinated with different stakeholders and Partners in this quarter through workshops, trainings, and series of meeting, such as refresher training for health worker and informal discussions at the village, sub district and district level with beneficiaries, local

government officials, and partners. Below is a table outlining the types of partnerships the program maintained and the activities conducted in collaboration.

Fig 16. Type of partnership With Stakeholders and Partners

Activity	Completed activities	Organization (Partnership)
Finalization of National Mother Support Group Flipchart	• Edited the flipchart based on field test results	• **National Government** MOH: Subdit. Binkes Ibu Hamil, Subdit. Binkes Ibu bersalin dan Nifas
National Hand Washing With Soap Day Campaign	▪ Attended meeting on preparation of National HWWS Day ▪ Supported IEC materials development of HWWS for newborns • Reviewed and discussed the hand washing for newborn survival IEC materials that would be used in MCHIP districts • Conducted preparation meeting to design the cascade ToF at province and district level on HWWS for newborn survival	• **National Government** MOH: Subdit Binkes Bayi, Subdit.Binkes Anak Balita, Pusat Promosi kesehatan, Subdit. Diare, Kecacingan dan infeksi saluran pencernaan lainnya, Subdit. PASD ▪ Unilever
Drafting National guidelines of C-IMCI	▪ Final editing of National C-IMCI guidelines ▪ National C-IMCI guideline has been pilot-tested in Berau, Kalimantan Timur (District which is interested to replicate C-IMCI)	• **National Government** MOH: Subdit.Binkes Anak Balita, Subdit. Binkes Bayi, Subdit. ISPA, Subdit. Diare, Kecacingan dan Infeksi Saluran Pencernaan lainnya • **UNICEF, WHO** • **WVI, Mercy Corps, Child Fund** • **Local Government** PHO: Kalimantan Timur, Aceh, Maluku, Papua, NTT and Jawa Tengah DHO : Kurim, Bireuen, Buru, Jaya Wijaya, TTS and Brebes
Finalization of Midwife's job Aid for IPNC	• Conducted series of meeting for final editing of Midwife's job Aid	• **National Government** MOH: Subdit. Binkes Bayi, Subdit. Binkes Ibu Hamil,

Subdit. Binkes Ibu bersalin dan Nifas

- **Professional organization**
  IBI
- **STIKES Mitra Ria Husada**

Sub-Objective 3: Improve Quality of Clinical Services at All Levels of Care

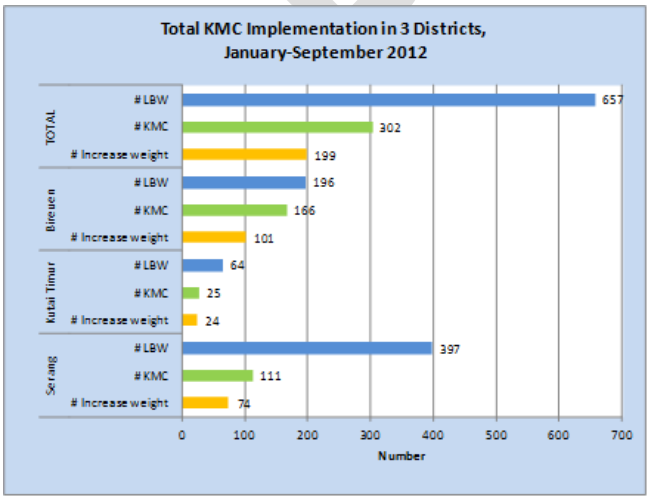
1. Kangaroo Mother Care (KMC)

MCHIP has expanded facility based KMC in three MCHIP target hospitals in the three districts. *Perinasia* (Indonesian Perinatologist Association) that had been leading the effort of establishing facility based KMC in Indonesia is providing technical assistance to MCHIP for KMC expansion.

To date, following components of facility based KMC has been established in all three district hospitals:

- Providers received comprehensive training for KMC including topics on learning organization (how to prepare hospital staff to adopt a new approach), Breastfeeding, and KMC.
- KMC team at the hospital established and responsible for advocating, planning, and budgeting for KMC
- Standard operational procedure for KMC in place
- Recording and reporting for KMC established
- Provision of IEC materials and KMC kits
- Official decree from the head of hospital with commitment and allocating resources for KMC

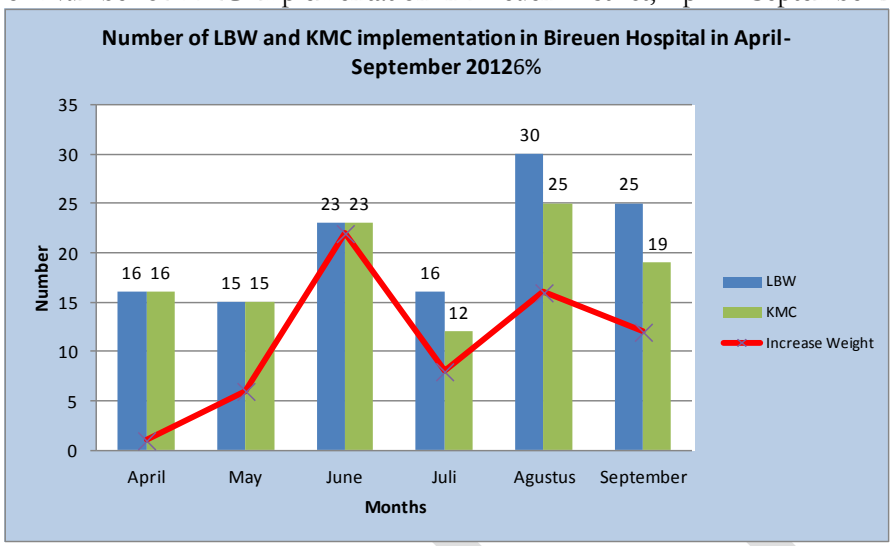
Fig 17. Total KMC Implementation in 3 Districts, January—September 2012



The data from the three districts from January through September shows a steady number of LBW cases that have received KMC at the hospital. Serang hospital had a disruption in KMC because of the move to a new facility, the services are now restored.

In Biruen, majority of LBWs in the hospital are receiving KMC with increase in weight. Some newborns did not receive KMC due to unstable condition, and birth weight <1000 grams.

Fig 18. Number of KMC Implementation in Bireuen District, April—September 2012



To maintain continuity of KMC from the hospital to the home, MCHIP continues to support the development of KMC programs at the puskesmas level. In Bireuen, series of socialization of KMC was conducted at the Puskesmas level to incorporate KMC into the postnatal care. The socialization was conducted for 18 puskesmas in Biruen and facilitated by the DHO Bireuen. As a follow up, the participants are to socialize the KMC to other staff in their puskesmas, implement KMC, and report the LBW data and those who receive KMC to the DHO.

Challenges and Lessons Learned

a) A challenge that was identified in all sites was the separation of mothers and newborns after birth. While newborns often stay in hospitals for a few days, mothers often leave early. However cost implications as well as household responsibilities will allow the mothers to stay only a few days at the hospital- a constraint for continued KMC practice. MCHIP is therefore, supporting the development of KMC programs at the puskesmas- the mothers can then continue to provide KMC with support from the bidans and the puskesmas staff.

2. ***Improved systems for quality assurance.***

Standards-Based Management and Recognition (SBM-R) is a practical approach to improving the quality of health care and the performance of service delivery systems. With technical assistance from Jhpiego, the approach has been implemented in over 20 programs in developing countries and across several health areas, including maternal child health, reproductive health, HIV/AIDS, and malaria Under MCHIP program, SBM-R has been implemented in three districts in the three Indonesia; Bireuen, Serang and Kutai Timur. Below are performance standards in SBM-R for Midwife, Puskesmas and Hospital level.

Fig 19. SBM-R Performance Standard at All Levels

Midwife Level	Puskesmas Level	Hospital Level
Tool 1. Pregnant women care Tool 2. Normal delivery and newborn care Tool 3. Mother and newborn postpartum care Tool 4. Delivery complication Tool 5. Contraceptive methods Tool 6. Family Planning – Oral contraceptive and injection Tool 7. Child immunization Tool 8. Under five children care Tool 9. Infection Prevention	Tool 1. Physical Facility Tool 2. Antenatal Care Tool 3. Pregnancy Complication Tool 4. Normal delivery and postpartum care Tool 5. Management of delivery complication Tool 6. Postnatal complication Tool 7. Postpartum care Tool 8. IMCI for newborn<2 months Tool 9. IMCI for 2 month to 5 years child Tool 10. Child Immunization Tool 11. Contraceptive methods Tool 12. Infection Prevention	Tool 1. Infection Prevention Tool 2. Pregnancy Complication Tool 3. Normal delivery, delivery, postpartum and newborn care Tool 4. Delivery complication Tool 5. Antenatal and postpartum care Tool 6. Family planning service in hospital

MCHIP has introduced SBM-R in 145 facilities (hospital, health center, and individual midwife practices) as a tool of reference for and to measure progress toward quality MNH services. There are 37 facilities in Bireuen, 91 facilities in Kutai Timur and 77 facilities in Serang implementing SBM-R.

Fig 20. Number of facilities implementing SBM-R in MCHIP target Area

SBMR Level	Bireuen	Kutai Timur	Serang
Hospital	1	1	1
Puskesmas	6	6	5
Midwife	30	84	71
TOTAL	**37**	**91**	**77**

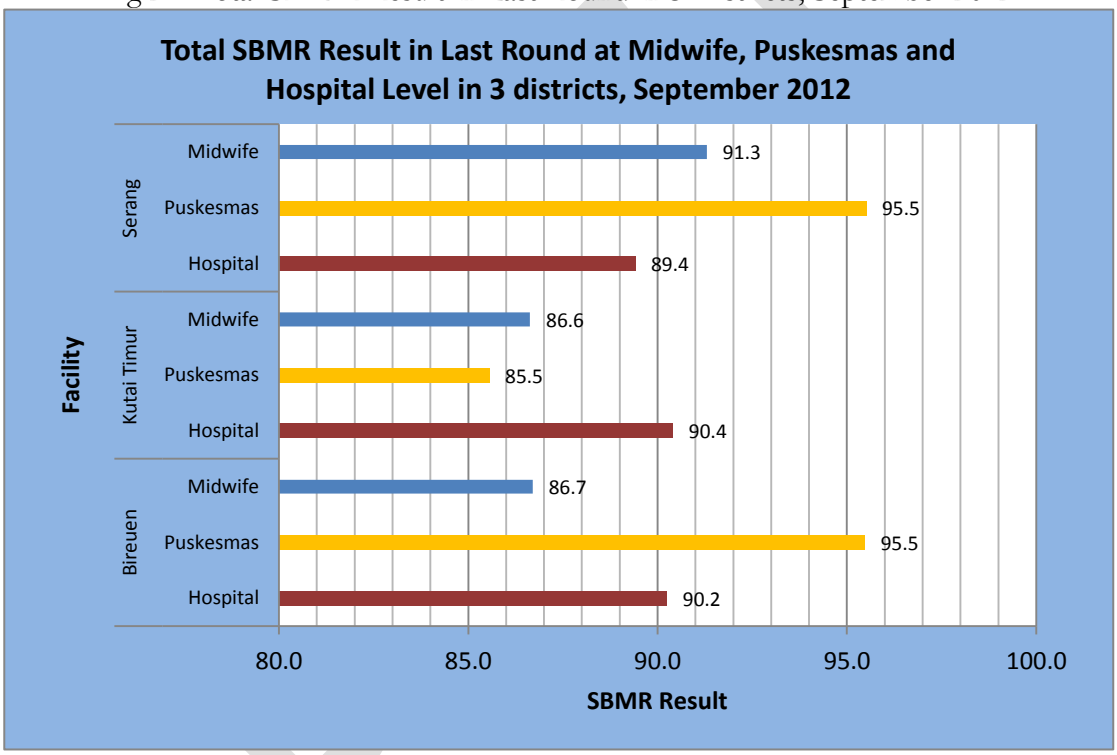
Standards-Based Management and Recognition (SBM-R) is a practical approach to improve the quality of health care and the performance of service delivery systems. The aim of SBM-R is to empower health care providers and managers to proactively and routinely assess services using evidence-based standards, and then improve the quality of services in response to those assessments. The process helps providers develop a sense of ownership of the assessment findings so that they become involved in making recommendations and implementing solutions. Individual and group self-assessments at each facility are highly encouraged to identify gaps in the quality of care that need to be addressed.

SBM-R is a four-step process that consists of setting performance standards, implementing those standards, measuring progress, and rewarding achievements. Managers and staff at facilities use SBM-R assessment tools to identify gaps. After conducting a cause analysis, facilities choose and implement appropriate interventions to close the gaps. Repeat assessments monitor progress. When implementing SBM-R, health workers are encouraged to focus on action and begin with simple interventions in order to achieve early results and create momentum for change.

In the cases if the providers or facilities couldnot handle the problem; such as equipments, building renovation and others who need much money the providers told their supervisor,

head health center, the supervisor would bring to Musrenbangkes (health plan meeting) in Village, Health Center/SubDistrict level.
Health Center and Hospital in District managements is belong to local government, so they should more active to revitalization, reequipt and fulfill the need of Health Center and Hospital to do their better performance for giving care to the communities.
Mostly everywhere, the health provider/the head of health center, hospital managements, just talked and proposed their need to Health Office and their hope this leader will propose to local government. Need to cut this system. MCHIP SBMR lesson learn, village midwife can proposed their need to the head of village through Village plan meeting. It is also work for Health center in subdistrict plan meeting. (success story from Kaubun, Rantau Pulung, Kaliorang and Telukpandan health center in Kutim.. Tirtayasa, Kramat Watu, Pamarayan PKM at Serang, Peusangan Selatan, Gandapura and Peudada Health center.
Figure below summarizes the SBM-R achievement for all MCHIP sites todate based on the last data collection at all facilities in 3 districts. All facilities comply with more than 80% of the standards on average.

Fig 21. Total SBM-R Result in Last Round in 3 Districts, September 2012



The gaps in skills identified during SBM-R assessment are supported through on the job mentoring. In Bireuen, during this quarter several on the job mentoring activities were held and facilitated by the staff from the puskesmas who were previously trained by MCHIP:

- Puskesmas Juli. Attended by 35 participants. Topic: AMTSL, PPH, Partograph
- Puskesmas Peusangan selatan. Attended by 22 participants. Topic : PPH , Asphyxia
- Puskesmas Peudada. Attended by 47 participants. Topic: AMTSL, PPH
- Puskesmas Gandapura. Attended by 43 Participants. Topic: Partograph
- Puskesmas Jeumpa. Attended by 24 participants. Topic: AMTSL
- Puskesmas Makmur. Attended by 22 participants. Topic : AMTSL, PPH, Partograph

In Bireuen, DHO conducted regular visit in July to the 3 puskesmas (makmur, jeumpa and peusangan selatan) , 13 village midwives in those puskesmas area and one district hospital. During this visit, DHO staff was also accompanied by village midwives coordinator and puskesmas coordinator. The visit identified several improvements in village midwives level, such as, the availability of trolley and sterilization processing kit and also more patients are now willing to deliver at village health facilities. At Puskesmas level, a higher number of delivery was observed, in puskesmas peusangan selatan and makmur. Infection Prevention is still an issue in the three puskesmas- continous refresher training and on the job mentoring on normal delivery, family planning, and complication during delivery is also required.

In Bireuen, at District Hospital, findings show that the rooms/ward was clean and there were improvements in normal delivery care and management of delivery complication. However, infection prevention has not met the standard -self protection kit has not been de contaminated after every medical treatment. Management of Infectious and non infectious waste also has not meet standard.

In Bireuen, sustainability of SBM-R program was supported through the facilitation of a SBM-R decree and schedule of regular monitoring with person in charge per monitoring. This draft has been submitted to the District hospital staff for approval.

Beyond the MCHIP target facilities, MCHIP facilitiated the expansion of SBM-R within the MCHIP districts and 8 additional districts.

Fig 22. Number of SBM-R Implementation in Target and Replication Sites

	Bireuen	Kutai Timur	Serang	Total
Number target facilities in MCHIP area implementing SBM-R	7 (6 Puskesmas, 1 hospital)	7 (6 Puskesmas, 1 hospital)	6 (5 Puskesmas, 1 hospital)	**20**
Number of village midwives in MCHIP area implementing SBM-R	• 28 village midwives under MCHIP Puskesmas • 19 village midwives under non-MCHIP puskesmas	84 village midwive	71 village midwives under MCHIP Puskesmas	**202**
Replication within MCHIP district	12 puskesmas and 47 village midwives	-	25 puskesmas	**37**
Replication in other districts	• Districts Pidie. (5 puskesmas, 2 hospital, 3 village midwives) • Districts Langsa (4 puskesmas, 45 village midwives)	• District Penajam Paser Utara District (1 hospital) • Bontang district (will be held on this October)	• District Tangerang (2 puskesmas, 1 hospital) • District Lebak (2 puskesmas, 1 hospital) • City Tangerang (2 puskesmas, 1 hospital) • City Tangerang Selatan (2 puskesmas, 1 hospital)	**8**

MCHIP facilitated a qualitative assessment of SBM-R and identified positive factors and areas for improvements. In summary, the village midwives, puskesmas, and DHO identified SBM-R as a useful tool to maintain quality of MNH services. The report also identified several areas

for improvement on implementation of SBM-R and maintaining sustainability and ownership post MCHIP. A detailed list of findings and recommendations for improvement is listed in Annex 2.

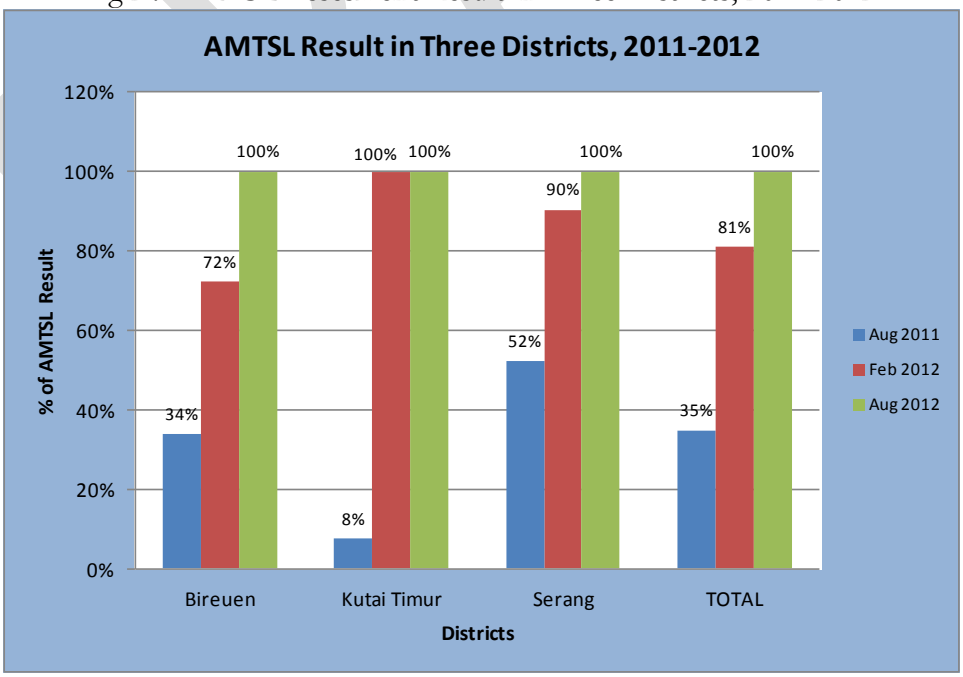
i. Active Management Third Stage Labor (AMTSL)

Fig23. Midwives competent in AMTSL in Three Assesments

Kabupaten	Survey	# of total midwives	# of midwives assessed	# of midwives competent	
Bireuen	Aug 2011	235	235	80	34%
	Feb 2012	273	226	163	72%
	Aug 2012	**218**	**218**	**218**	**100%**
Kutai Timur	Aug 2011	67	53	4	8%
	Feb 2012	80	57	57	100%
	Aug 2012	**102**	**85**	**85**	**100%**
Serang	Aug 2011	100	94	49	52%
	Feb 2012	98	93	84	90%
	Aug 2012	**96**	**92**	**92**	**100%**
Total	Aug 2011	402	382	133	35%
	Feb 2012	451	376	304	81%
	Aug 2012	416	395	395	100%

While the percentage of Skilled Birth Attendant (SBA) in Indonesia is high, the quality of SBA needs further improvement. MCHIP in three districts conducted an assessment of the AMTSL skills of the midwives in the coverage area. The AMTSL skill for an average of 400 midwives was assessed three times over a period of one year on models or clients when available. All midwives are now demonstrating 100% competency in all three steps of AMTSL. The increase in competency can be attributed to intense on the job mentoring and supportive supervision provided by the midwife coordinators and facilitated by MCHIP.

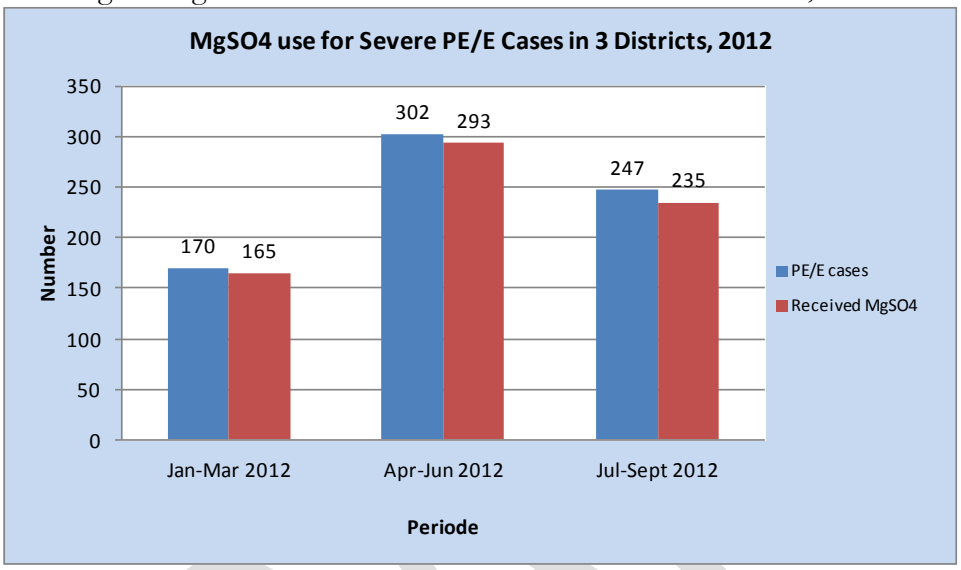
Fig 24. AMTSL Assesment Result in Three Districts, 2011-2012



ii. Magnesium Sulphate administration

Magnesium sulphate administration to several pre-eclampsia is being supported by MCHIP through the on the job training and mentoring as the part of SBM-R. While there has been an increase in use of magnesium sulphate at the community level esp. in Serang, administration of magnesium sulphate needs to be strengthened. Lack of confidence and limited cases serve as deterrent to use of magnesium sulphate. Puskesmas data from the three districts shows majority of severe PE/E cases this year have received MgSO4 prior to referral.

Fig 25. MgSO4 Use for Severe PE and E in Three Districts, 2012



Challenge and Lesson Learnt

a) MgSO4 is sometimes not available at the health centers and the pharmacy. According to the DHO, they need to request this from PHO, and PHO in turn requests from the MoH.
b) The cases of Pre-eclampsia and eclampsia are few and maintainence of management skills is a challenge. Consistent on the job mentoring from the Midwife coordinator to the village and puskesmas midwives to maintain skill should be practiced.

Other clinical mentoring

- In Serang, midwives of P2KS Cirebon, P2KS Jakarta, and P2KS Banten conducted on the job training at 5 Puskesmas. The OJT was conducted for 3 days, to strengthen Infection Prevention, Delivery, and ANC care in day 1; visit Polindes in day 2; follow by partograph, discussion and develop action plan in day 3.
- In Serang, 60 health care providers including village midwives, Puskesmas midwives, and coordinator midwife participated in strengthening clinical skills on APN, breastfeeding, and AMTSL. This is done routinely every two to three months in the target districts. The mentoring was conducted by P2KS trainers with facilitation from MCHIP. Village and puskesmas midwives attended this on the job mentoring session.
- In Kutai Timur, routine on the job mentoring carried out in MCHIP Puskesmas area for clinical topics including MgSO4, AMTSL, Infection prevention, and also recording and reporting. The mentoring is aimed to increased the capacity of health provider to treat complication.

- Minor renovation of 4 puskesmas is ongoing in Serang with planned completion at the end of October: Petir, Padarincang, Tirtayasa, and Pamarayan. This activity was previously planned for the quarter before, but was not implemented because of administrative challenges. These renovations focused on minor supplies and renovations for infection in the delivery room.

3. Training.

iii. APN Training

Normal delivery or APN Training was conducted for 7 midwives from MCHIP Puskesmas in Kutai Timur. The training was conducted in P2KS Samarinda. Goal of APN Training is to increase skills to provide normal delivery and management of complications together with the referral. In class training was followed by clinical practicum and each participant managed three deliveries. RSUD Sangatta covered budget of travel cost and perdiem of participants from hospital during the training (5 days only) and MCHIP covered budget of training package, and the facilitator fee.

iv. PONED

In the previous quarter, assessment for PONED was conducted by the DHO, District hospital and P2KS and facilitated by MCHIP in the three Puskesmas in Bireuen and four Puskesmas in Kutai Timur. All Puskesmas are currently providing PONED services. The team assessed the availability of resources, identified challenges, and proposed solutions in the implementation of PONED. Some of the challenges identified were:

- Limited skills and confidence amongst the puskesmas staff
- Lack of supplies, equipment, and ambulance either not available or in a bad condition hampering referral
- Rare xases of obstetric complications
- Process of referral to the RSUD delayed due to bad road, rain etc.

In this quarter, Bireuen sent 30 participants from Peudada, Gandapura, and Peusangan Selatan Puskesmas to join PONED training in Banda Aceh.Minor renovation for 4 Puskesmas and equipment supply for hospital, Puskesmas and polindes in Serang district was also provided in this quarter.

v. *PONEK*

The emergency units at the district hospital are not well equipped to receive maternal and newborn emergency cases. The emergency skills and equipments remain substandard and the obgyn/pediatrician is not available on -site for 24 hour. Saiful Anwar hospital (RSSA) is one of the best national referral for maternal and neonatal emergency care in Indonesia. MCHIP facilitated CEONC team form Sangatta hospital and BEONC team from selected puskesmas to visit RSSA. The participants visited the emergency unit, perinatal room, and delivery room. They also observed the service in the emergency unit, room-setting, triage, nurse station, tools, medicine, logistic, ambulance team, NICU, maternal and perinatal unit. For Bireuen and Kutim the participants are tasked with sharing their learnings with the hospital management and advocating for funds for the Emergeny Room staff training to RSSA. Serang already implemented MNERC with MCHIP funds

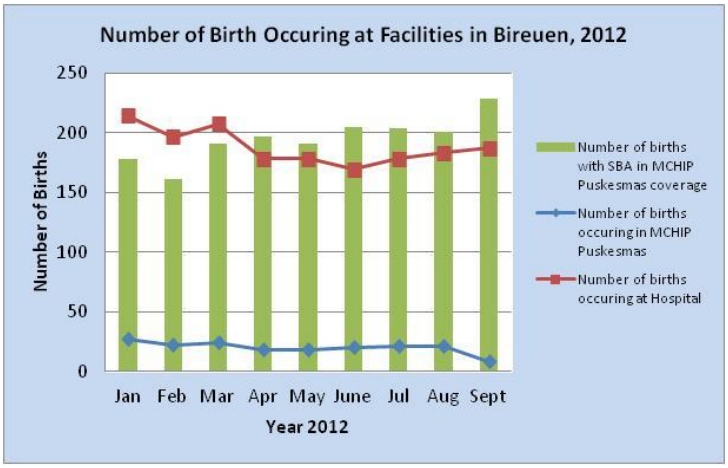
Challenges and Lessons Learned

a. Limited number of Ob/Gyns and Pediatrician in each district. To address the gap, MCHIP is strengthening the skills in handling emergency cases of the General practitioners and senior midwives through on the job training, mentoring, supervision, and internship in RSUD. MCHIP advocated through PTP and DTPS for the provision of budget for these internship.
b. Using P2KS for training and clinical mentoring is cost effective and in line with recommended guideline, however, there have been several cases where the verification from P2KS has been biased due to a personal relationship with the participants. Using P2KS from other districts for verification is an option; however, this would reduce the opportunity to develop the capacity of P2KS from the district for monitoring.
c. Training models such as the resuscitation and pelvic models are currently either available at the P2KS or through MCHIP, puskesmas do not have the budget to purchase these models that cost around 1000 USD. Easy access to these models would increase the capacity of the puskesmas to conduct on the job training for the puskesmas staff as well as the desa staff independently.
d. Conflicts and differences in opinion between and within the primary stakeholders, DHO, P2KS, district hospital, and puskesmas can lead to challenges in program start up and effective coordination and implementation. Relationship between these sites for example between puskesmas and district hospital are at times improved when the puskesmas is able to stabilize and refer clients in a better condition.
e. Emergency unit in District hospital is not yet standardized (HR, Facilities, management) and ob/gyns and paediatrician are either not available or only available for a few hours.

Birth at Facilities

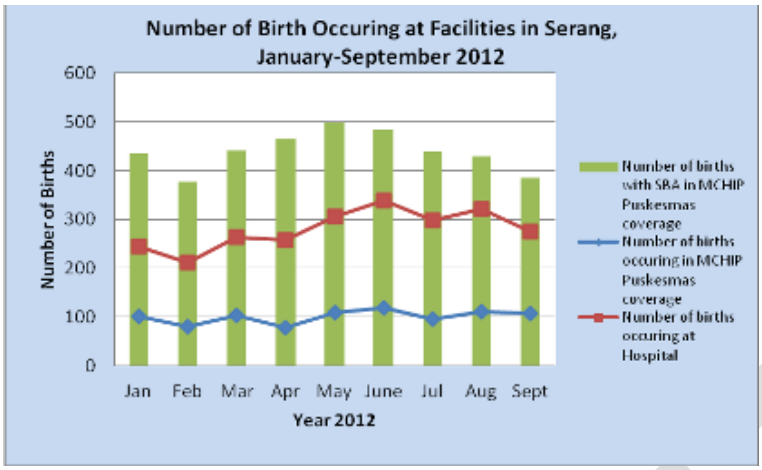
MCHIP considers Births in facilities as a positive program outcome. As reported in the PWS/KIA data from the three districts, birth at facilities (hospitals and puskesmas) made up 40% of all deliveries with skilled birth attendant (89% in Bireuen, 45% in Kutai Timur, 48% Serang) for this quarter in the MCHIP puskesmas coverage area.

Fig 26. Number of Births occurring at facilities in Bireuen



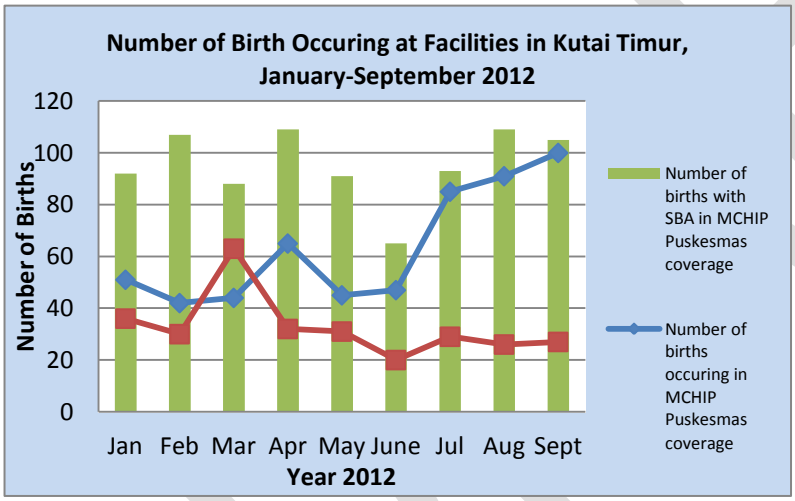
In Bireuen in the six MCHIP puskesmas coverage areas/ subdistricts, the number of births with SBA has increased slightly. The number of births occurring in the MCHIP puskesmas remains consistent. This may be due to a higher number of births occurring at the *polindes* that are closer to the population. On a site visit to two *puskesmas* in Bireuen, the *puskesmas* felt that delivering at the *polindes* in their catchment area is satisfactory- since the midwives have received similar training and are supervised by the puskesmas midwife, and have access to the puskesmas when needed (availability of a transport mechanism and system).

Fig 27. Number of Births occurring at facilities in Serang



In Serang in the five MCHIP puskesmas coverage areas, the number of births with SBA had declined. The number of births occurring at the puskesmas is low and consistent at an average of 100 births per month or 22% of all births due to SBA. Village and private facilities also provide SBA services in Serang, offering more choices to women and their families.

Fig 28. Number of Births occurring at facilities in Kutai Timur



In the six MCHIP coverage areas for Kutai Timur, on average 92 births a month is being assisted by the skilled birth attendants, this is equivalent to 55% of all birth in the area. In this reporting period, on average 80% of the births assisted by SBA are happening at the puskesmas, this is higher than other MCHIP sites. Unlike Bireuen and Serang, Kutai Timur has limited choices for delivery, the number of private facilities and village midwives are limited. In Kutai Timur delivery at the hospital is low because referrals from the MCHIP site are also being made to the district hospital in Bontang.

Sub-Objective 4: Improve Management of the District Health System

a. Evidence-based Local Planning.

Evidence-based local planning involves a series of processes toward ensuring evidence based planning and budgeting for district level activity for all programs. MCHIP is facilitating the evidence based planning process for MNCH for the target districts. The evidence based planning is completed on an annual basis and is bottom up from the community level to the district level. The village or the community level planning or *pra-musrenbangdes* is followed by the sub-district level planning at the puskesmas called the *Perencanaan Tingkat Puskesmas* or PTP that feeds into the District Team problem solving (DTPS) at the district level. In 2010/11, MCHIP facilitated the completion of the process in all districts; the result was a significant increase in budget allocation for MNCH for 2012. The planning for 2013 allocation is ongoing in all three districts with only limited facilitation from MCHIP. The capacity building and resources facilitated by MCHIP for 2012 allocation remains strong and active.

Challenges and lessons learned

a) Beyond the completion of Perda APBD, DTPS and Advocacy team at the district level for MNCH needs to work hand in hand for consistent advocacy to the parliament to seek appropriate support for the MNCH programs as the competition for the funds is high.

b. *Improved process for conducting maternal-perinatal audits.*

Effective maternal and perinatal audits are associated with improved quality of care and reduction of severe adverse outcomes[1]. Maternal Perinatal Audit (MPA) is for tracking the causes of maternal and perinatal morbidity and mortality to prevent future cases. MCHIP in all three sites in collaboration with the DHO introduced the revised MPA forms and strengthened the MPA process. All districts are now conducting Verbal Autopsy for all deaths, with reviews for selected cases.

The percentage of maternal and neonatal deaths audited has increased in the last two years-with close to 100% maternal and neonatal deaths being audited in all three districts. In this quarter, total deaths with autopsy verbal are on average 100% (n=61) for three districts (each district 100% in Bireuen (n=15), Kutai Timur (n=18) and Serang(n=28).

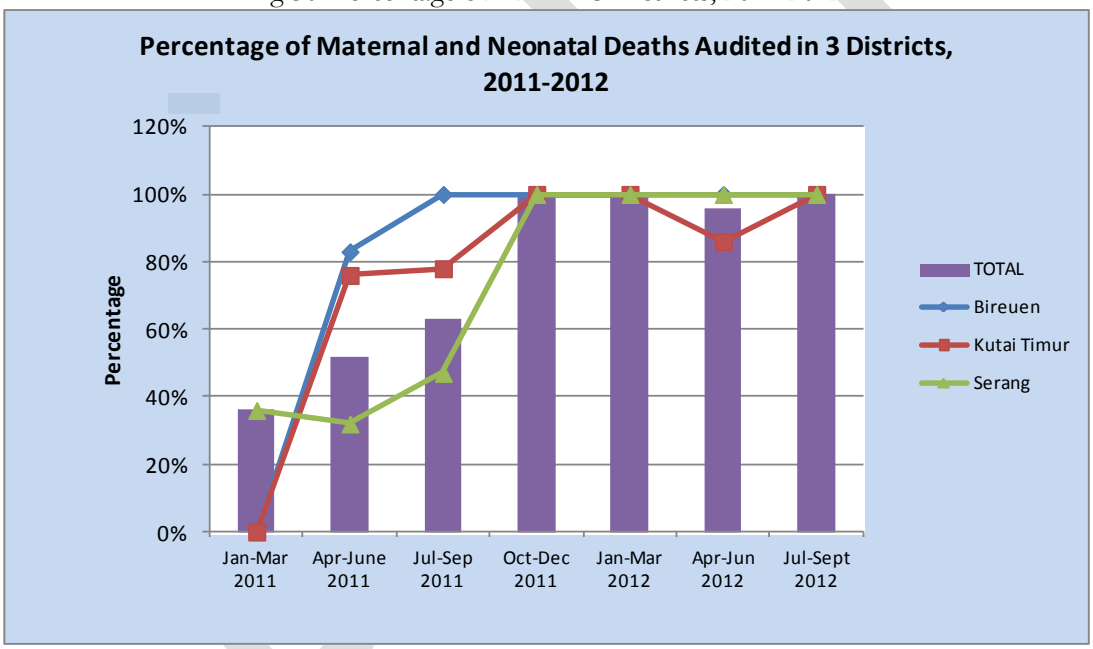
[1]Pattinson RC, Say L, Makin JD, Bastos MH: Critical incident audit and feedback to improve perinatal and maternal mortality and morbidity. *Cochrane Database Syst Rev* 2005, (4):CD002961.

Fig 29. Number of Maternal and Perinatal Deaths Audited in 3 Districts, 2011-2012

Deaths and Audited		Jan-Mar 2011	Apr-Jun 2011	Jul-Sept 2011	Oct-Dec 2011	Jan-Mar 2012	Apr-Jun 2012	Jul-Sep 2012
Number of deaths audited	Maternal	4	12	4	1	9	1	10
	Neonatal	22	32	50	37	55	31	51
Total number of maternal and neonatal deaths	Maternal	8	10	5	1	9	1	10
	Neonatal	44	74	87	37	55	33	51
% of reported maternal and neonatal audited		**50%**	**52%**	**59%**	**100%**	**100%**	**96%**	**100%**

Selected cases are reviewed by a team of expert on a regular basis. In Serang in July, review of autopsy verbal was conducted for 4 maternal deaths. The cause of maternal deaths are postpartum haemorhage, and eclampsia. Three of maternal deaths happened in hospital, and one in the village. Series of recommendation were generated by the AMP team.

Fig 30. Percentage of MPA in 3 Districts, 2011-2012



Challenges and Lesson Learned.

While verbal autopsies and reviews are happening – responsibility for facilitating the action items identified by the team of experts remains unclear. Effort needed to plan and dedicate resources based on the majority of maternal and neonatal death causes. MCHIP plans to raise this issue at the close out meeting in Jakarta with the MoH and the district and the provincial teams.

c. Institutionalized commitment for MNCH.

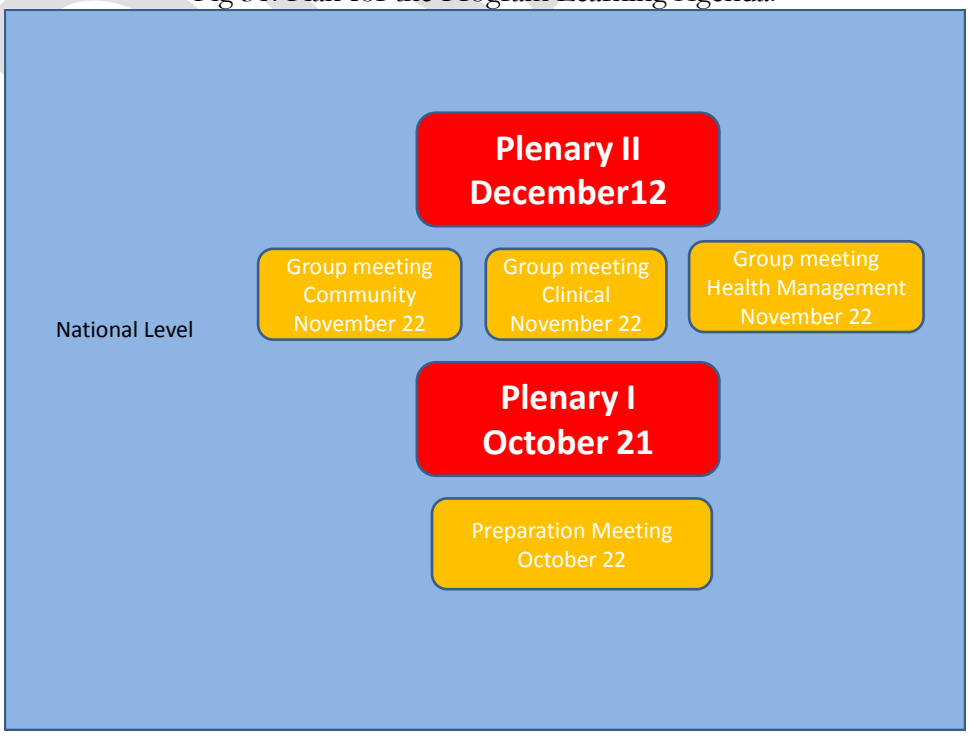
In this quarter, MCHIP facilitated the approval of Qanun KIBBLA or Perda KIBBLA by the new Bupati. The Qanun KIBBLA is a regulatory commitment from the local government toward the MNCH programs. Perbub KIBBLA is required to further sustain this commitment at the local level. MCHIP will bring this issue to the national program learning and put as strategic of priority for Bireuen district team for follow up post MCHIP.

PROGRAM LEARNING AGENDA

MCHIP is planning to organize a series of program learning meetings at the national level. The purpose is to provide feedback to the MoH on how to facilitate roll out of national programs in the provinces and districts learning from the MCHIP experience. MCHIP districts will share the results, challenges, lessons learned, and best practices with the MoH and the stakeholders, and identify and assign concrete follow up items. The planning for the Program learning sessions are:

- Preparation meeting with MoH in October
- Plenary Session I to set the stage and agenda November
- Parallel discussion between technical group, conducted in November. The team will be divided into 3 groups- community, clinical, and health management component. The groups will conduct meetings to discuss detailed strategies and follow up actions for each component.
- Plenary Session II, in December. The workshop to deliver the results from technical team on the detailed strategies and action plan.

Fig 31. Plan for the Program Learning Agenda.



WORKPLAN

The following will be conducted in 3 districts in October 2012. Most of activities are follow up for replication, and monitoring and evaluation. The table below summarizes the list of activities in October.

Fig 32. MCHIP Activities October 2012

No	Activities
BIREUEN DISTRICT	
1	Evaluation meeting for Replication at the province level
2	TOF DTPS for Aceh Tamian
3	Technical assistance DTPS for replication
4	Technical assistance Kelas Ibu for Aceh Tamiang, Bener Meriah
5	Technical assistance C-IMCI
6	Staff development
7	Recognition for Villages
8	PONEK Training
9	Providing equipment for emergency
10	Data validation for MNCH program
11	Quarterly review MNCH program
12	Advocacy Perda KIBBLA
13	Develop guideline for POMA implementation
14	Meeting strategy for program sustainability
15	Program Learning Workshop at district level
KUTAI TIMUR DISTRICT	
1	Workshop replication SBM-R and Kelas Ibu for Sub-districts in Kutai Timur
2	Workshop replication for Bontang district
3	Monitoring and supervision of health worker C-IMCI at national level
4	Monitoring and supervision of health worker C-IMCI at district level
5	HWWS for newborn campaign at district level
6	MPA review at national level
7	Magnesium Sulphate Training
8	Program Learning Workshop at district level
SERANG DISTRICT	
1	Workshop replication for SBM-R for Pandeglang district
2	On the job training PWS-KIA
3	Develop Mini University video
4	Recognition for villages
5	Additional equipment for 5 Puskesmas for BEONC
6	Minor renovation for 5 Puskesmas
7	Emergency drill PONED-PONEK (MNERC Training)
8	Follow up KMC

9	MPA review at national level
10	Quarterly review by MNCH team at district and subdistrict level
11	Midterm review MCHIP program
12	Program Learning Workshop at district level

MANAGEMENT

Bumi sehat

Upon request from USAID, MCHIP hired a consultant to develop a business plan for Bumi Sehat, a birthing clinic initiated by Robin Lim, recipient of the CNN hero of the year award 2011. MCHIP is also processing a grant of 27,000 USD to Bumi Sehat for one year to support Midwifery training.

MCHIP Close out

Field offices are planned to close out in October with reduced staffing functioning in Jakarta for the month of November and December, planning for the close out meetings and documentation. Close out and Recognition Ceremonies organized in all three districts in October, 2012.

PMP

- **General MNCH Indicators.** Indicators 1-4 increased in all three districts in this quarter. Serang and Bireuen will most likely reach the annual target in the next quarter, Kutai Timur will not. Kutai started out much lower than the other two districts, and remains plagued with the issues of access and infrastructure. Indicator 5- percentage of births occurring at the facility for Bireuen has not been received.
- **SO1.** MCHIP has met and exceeded its target on the districts and sub-districts that received technical assistance from the MCHIP districts for replication.
- **SO2.** Indicator 11- national guidelines drafted for C-IMCI, and IPNC. Indicator 12- the number of perdes established for Bireuen was achieved in this quarter, after the Qanun KIBBLA was signed by the new Bupati.
- **SO3.** Indicator 15- AMTSL competency increased to 100% for the midwives in the three districts. Indicator 17- MgSO4 treatment prior to referral in this quarter was below 100% for Kutim and Serang. Indicator 19- KMC in hospital was restored in Serang following the move.
- **SO4.** Indicator 20- The number of district MNCH team in Bireuen remains 1, despite the approval of the Qanun KIBBL, the district MNCH team has not yet been formed, and will require some time. Indicator 21- number of participants for DTPS and PTP remains low- the plans for the PTP was downsized to one session in each district instead of one in each puskesmas, and was attended by fewer numbers of participants.

Annex 1. MCHIP Tracking Indicator

No	INDICATOR	Project Target	Jul-Sept 2012			
			Bireuen	Kutai Timur	Serang	TOTAL
Program Objective/Strategic Objective: Increased utilization of quality district-based integrated MNCH services, and practice of healthy maternal and neonatal behaviors in the home?						
GENERAL MNCH INDICATORS						
1	Proportion of women who receive at least 4 antenatal visits*	95%	68%	38%	51%	53%
2	Proportion of deliveries with a skilled birth attendant in MCHIP program areas*	90%	65%	42%	71%	64%
3	Proportion of newborns who receive postnatal visits during the first week of life*	80%	68%	38%	76%	66%
4	Proportion of women who receive postnatal visits during the first week of life*	80%	65%	35%	72%	63%
5	Percentage of births occurring at facilities*	10%	28%	24%	23%	25%
6	Number of people trained in maternal/newborn care through USG supported programs	6,500	2,330	2,115	2,918	7,363
Sub Objective 1: **Effective implementation of MDG Roadmap for scaling up life-saving interventions to achieve MNCH impact at scale within three remote provinces**						
7	Number of subdistricts in MCHIP target districts that receive technical assistance from MCHIP for scale up**	17	15 (68%)	13 (92%)	7 (100%)	35
8	Number of districts in MCHIP provinces that receive technical assistance from MCHIP for scale up **	23	12 (100%)	13 (100%)	25 (100%)	50
Sub Objective 2: **Improved Maternal and Newborn Care Services and Practices at the Community Level**						
9	Number of districts where C-IMCI established	2	1	1	NA	2
10	Number of districts where Community KMC established	2	1	1	NA	2
11	Number of national policies drafted with USG support	1	NA	NA	NA	2
12	Number of Perdes established	80	62	48	35	145
13	Number of National level public-private partnerships	1 ppp	NA	NA	NA	4
Sub Objective 3: Improved Quality of Clinical Services at all Levels of Care						
14	Number of health facility implementing QA/QI approaches	20	7	7	6	20
15	Percentage of village midwives in MCHIP supported areas are competent in AMTSL	100%	100%	100%	100%	100%
16	Percentage of target facilities achieving at least 60% of performance standards	100%	100%	100%	100%	100%
17	Percentage of women who come to target Puskesmas and hospital treated with MgSO4 prior to referral	100%	86%	41%	100%	98%
18	Number of puskesmas PONED treating complications	6	1	6	5	12
19	Number of district hospitals with KMC established	3	1	1	1	3
Sub Objective 4: Improved Management of the District Health System						
20	Number of MNCH teams established at district and subdistrict level that meet regularly	15	1	7	6	14
21	Number of people trained in DTPS and PTP workshop	420	50	50	69	169
22	Number of districts with MNCH plans and budgets linked to DTPS	3	1	1	1	3
23	% of reported maternal or neonatal deaths audited	100%	100% (15 of 15)	100% (18 of 18)	100% (28 of 28)	100 % (61 of 61)
24	Number of local regulations and laws adopted	50	71	30	47	148

Annex 2: Success Story

My name is Umi Siswati. I am a midwife in Kadungan Jaya village, in the sub-district of Kaubun, East Kutai district, East Kalimantan province. MCHIP is working in the sub-district of Kaubun to improve the lives of mothers and newborns. It was a Tuesday morning, on March 20th 2012, around 8:00 am. I was working in the Kadungan Jaya Health Center in Kaubun. A family member of a patient came to me and told me his daughter-in-law was in labor and the dukun (TBA) told him to fetch a midwife. I asked him to sit while I checked the delivery information pouch, and I found the daughter-in-law's card. Written on the card were the patient's name, Mrs. Jamilah, her age, her address, her race and religion, and her estimated delivery date, which was 23 March 2012.

I quickly prepared my midwife kit and my medical supplies pack. I put on my boots because it was raining, and I rode on the back of the motorcycle with the father-in-law to the house where the patient was waiting. The house was ten minutes from the health center. In the patient's house, her family members were waiting in the living room. I went into the bedroom to greet the patient, her husband, and the TBA, who had all been there since the patient felt stomach pains earlier in the day.

After asking for permission, I examined the patient -she was in pain, so I stopped and massaged her. After the pain subsided, I continued with the examination. According to the TBA and the husband, the patient's water broke at around 6:30 am. After a quick examination I discovered the water was clear in color, so I told the patient she could start to push when she felt the urge to push, and when there was no urge, I suggested that she rest, eat, and drink. When the baby's head was 5-6 cm from the vulva, I put on the self-protecting gear to assist with the birth. At 9:00 am, a male baby was born, crying and healthy. I dried him, clamped the umbilical cord, changed him, put him on his mother's stomach, and started the early initiation of breast feeding.

My attention turned back to the mother; I gave her oxytocin and 10 units of IM immediately. Then I started performing controlled cord traction of the umbilical cord. The placenta was discharged at 9:06 am and was seemingly complete, and then I massaged the uterus for 15 seconds with no contraction. I saw her blood flowing like tap water. The sarong underneath the mother was full of blood, and even the floor was covered with blood. I guessed there were about 500cc of blood. I was perplexed and panicked, and I thought if the bleeding didn't stop, the mother could die. I prayed to Allah, and I performed the management of her uterine atony bleeding using a blood clot. I emptied her bladder and put my hand inside her vagina after I asked her permission. I told the dukun and the husband that the patient was having a hemorrhage.

I did an internal compression bimanual for 5 minutes until finally, there was a contraction. I kept it up for 2 minutes after the fundus became hard, then I slowly extracted my hand from the patient's vagina and checked the placenta. The placenta seemed complete, but I checked for a tear. Apparently, there was a two-degree tear. I informed the patient and suggested a suture. She agreed, and I immediately did two sutures on the inside, and three on the outside. After that, I observed the patient for another two hours to make sure she wouldn't hemorrhage again (Monitoring Stage IV). Her results were within normal range, and I recorded this in the partograph.

I examined the baby, and weighed and measured him. I then gave the mother an injection of Vitamin K and eye ointment to the baby eye, after explaining the benefits to her. I gave the baby to the mother and did the early initiation of breastfeeding, while counseling the mother on exclusive breastfeeding and early initiation of breastfeeding. I told the family to prepare some sweet tea and bring water for the mother to clean herself. I told them to contact me if they need any assistance or if they have any questions. The family thanked me over and over again, and they seemed very grateful for my services.

I thanked Allah who helped me save the patient. When I arrived back at the health center, I felt relieved and happy. It is an ongoing battle and takes dedication to be a village midwife. We have to be strong and independent when facing all the problems we encounter in our work. If not for us, who else could the village people turn to for help with health issues? Keep your spirits up, fellow village midwives!

Annex 3: Major Findings from the SBM-R evaluation report

MCHIP has completed to implement SBM-R evaluation report in Serang and Bireuen districts as the follow up survey from SBM-R Baseline data collection in 2011. The survey using qualitative approach in 3 Puskesmas and 3 villages in each district. The evaluation serves following four puposes:

Fig xx. Selected Puskesmas and Villages in SBM-R Evaluation

District	Puskesmas	Villages
1. Bireuen • DHO • Hosp	1. Gandapura	1. Monjambe
	2. Makmur	2. Blang mane
	3. Peudada	3. Paya Beunot
2. Serang • DHO • Hosp	4. Pamarayan	4. Pasir limus
	5. Padarincang	5. Curuggoong
	6. Kramat Watu	6. Terate

- To provide recommendations and guidance to improve the implementation of SBM-R in these districts as they scale up and also in other districts new to SBM-R;
- To generate discussions and further questions about the SBM-R implementation process;
- To identify factors toward sustainability and institutionalization of SBM-R
- To provide guidance to program and M&E staff concerning the methods and tools used to evaluate the SBM-R process.

The conclusion findings from the Evaluation described for each level in Bireuen and Serang districts are as follows:

1. Ownership of the SBM-R process
   - Realize the importance of SBM-R, DHO has expand its implementation to other PHCs started with baseline data collection
   - Implementation of SBM-R in health center has increase awareness of health providers e.g. use of PPE to prevent them from infection, at village midwives they even willing to provide it with their own money when there is no support
   - PHC supports SBM-R by providing budget from its operational e.g. buy consumable products and maintenance for the equipment
   - Replication has been undertaken by one health center, but lack of ownership is still apparent.
     - Not every health centers understand the role of health center and MCHIP, e.g. there is perception that assessment is part of MCHIP's responsibility.
     - Not all village midwives, even coordinator midwife, kept the copy of evaluation result.
   - The hospital acknowledged SBM-R as they own needs to provide best care for the patients, but dependency to MCHIP is still shown.

2. Performances standards development and validation
   - There are differences between the external assessment in Serang and Bireun: DHO Bireun feels they are not competent enough to be assessor. Assessor must have certain competencies, while they have not been trained for all components.
   - Internal assessment is done by village midwives and head of health center. There are difference perception, there is a Coordinator Midwife feels that assessment is not the health center responsibility.

- Assessment period usually every three month, however fulfillment of tools and evaluation meetings mostly follow MCHIP schedule.

3. Competency of internal and external assessors
    - External assessor is chosen by MCHIP in the initial assessment (IBI, P2KS), DHO did not know the criteria of assessor. After conducting 3 times assessment, DHO Bireun is involved to assist external assessor from MCHIP. Currently external assessor was DHO staff and MCHIP staff. DHO did not specially trained to be assessors.
    - In Serang DHO, internal assessor is carried out by Coordinator Midwife with assisted by KIA coordinator in order to assess village midwives. Most of Coordinator Midwife feel quite competent because they have been trained about component in services (e.g. infection prevention, MgSO4, etc.), and also because it is a common practice that should be done.

4. Analyzing performance gaps and implementing interventions
    - The facilities have analyzed their performance gaps. However, data processing is still relying on MCHIP's assistance, to some extent. For example, in the calculation of SBM-R final score using the "calculator", input of data in the excel sheet.
    - Action to fill in the identified gaps is discussed at the evaluation meeting, where priorities are determined (usually the priority is the low cost and easy intervention). The solutions taken could be vary, ranging from propose certain item through DHO planning, using financial resources available at health center level, propose certain item through health center planning (*PTP*) and *Musrenbang*, till using the staff own money. At village level, midwives have shown innovation in fill in the gaps, i.e. create a substitute for washtafel using bucket equipped with tap, create demonstration instrument for contraceptive tool.
    - Limitation in providing adequate counseling is compensated through Mother Class activity. Solution to budget limitation for supervision is by integrating it with other activities. At hospital level, when they ran out of stock of post-partum Vitamin A supplementation, the midwife told the mothers to ask for it to village midwife.
    - Solutions that are still challenged is request to DHO which sometimes constrained by the limited budget; request through *Musrenbang* which are mostly not succeeded due to low support from the cross-sector.

5. Ability to mobilize sufficient resources and technical support to implement their corrective action plans
    - At the early phase of SBM-R implementation, facility needs are fulfilled by MCHIP. Currently facilities have able to mobilize their resources and technical support in meeting the standards. The DHO, health centers, and village midwives sit together in evaluation meeting to discuss problems and determine plan of action, e.g. fulfillment of facilities, training to improve midwives' skills, etc.
    - Financial resources used are the DHO budget, health center operational fund, *Bantuan Operasional Kesehatan*/BOK (Health Operational Assistance), and *Jaminan Kesehatan Aceh*/*JKA* (local funded insurance for the poor). While at village level, the needs are mostly financed using midwife's own money.
    - In regard to cooperation with cross-sectors, it was found that the health center has not been able to mobilize technical support from other sector. For example, in obtaining tool for Stimulation of Early Detection and Early Growth and Development (*SDIDTK*)

6. The roles of district supervisors in improving quality and the supervision on SBM-R

- In the two districts, the DHO plays role as district supervisor for implementation at both health center and village level.
- The supervision is conducted in several ways, i.e. specific SBM-R supervision with MCHIP, integrated with existing supervision mechanism (e.g. regular meeting of coordinator midwives, Regional Supervision/*Bina Wilayah*, Technical Assistance/*Pembinaan Teknis*). Initiative for supervision with MCHIP mainly still comes from MCHIP.
- Supervision is not only conducted through checking of the filled-in tools, but also verified by assessing the midwives' skills, observing facility completeness. Feedback is delivered directly during supervision.
- For implementation of SBM-R at hospital level, currently the external assessment is only conducted by MCHIP, thus there is no district supervisor. Internal supervision is done by involving the chief of ward and management level.

7. The success of SBM-R process in improving services and coordination with the community outreach interventions to improve quality
   - In general, SBM-R is acknowledged to contribute in improving quality of care. The improvement is resulted from improved hygiene, more complete facilities/equipments, use of personal protective equipment, and staff compliance to standards. Quantitatively, this improvement is apparent from the increased score since the baseline up to the latest assessment cycle.
   - In terms of community outreach service, action to address the gap identified through SBM-R has been taken by health center, i.e. collaboration with the *Program Nasional Pemberdayaan Masyarakat/PNPM* (National Program for Community Empowerment) for establishment of *Posyandu* building, improvement of post-partum and neonatal visit.

8. Impact of recognition had on staff motivation and improvement in quality of service
   - Recognition provided is mainly supported by MCHIP, such as reward for health center or village midwife that achieved the highest score. Most health centers do not have certain budget allocation to provide reward for the staff. The types of recognition vary, from material and non-material rewards such as congratulation and applause during evaluation meeting.
   - Recognition is admitted as having effect on staff motivation and performance. It also encourages the staff to do certain action to improve their facilities and to get priority for fulfillment of needs.
   - Reward creates competition spirit among health centers and among midwives to reach highest score.

9. Perceived and expected services based on the perspective of the community (mothers)
   - Perceived services in general, according to mothers:
     - Midwives are nice, friendly, and patience
     - Midwives provide counseling in each examination/visit.
     - Information explained by the midwives is not limited to reproductive health, but also included heath in general, e.g. personal hygiene, nutritious food, etc). Midwives also discussed about preparation for delivery.
   - The weakness of midwives' service highlighted by the mothers is that midwives are not always in place due to other activities, e.g. at the health center or DHO. Such situation caused changing in the service schedule, e.g. *Posyandu*.
   - Expected services:
     - Service should be delivered in a good manner, i.e. nice, friendly, patience

- Midwife should provide counseling
- Midwife should be easily accessed anytime and willing to come to the mother's house when needed
- The need to have at least two midwife assisting delivery thus the service will not be interrupted when other patient come
- Delivery facility should be a designated place, e.g. *Polindes*, thus the facility will be adequate.

Set of reccomendation derived from the survey for each level:

1. From the implementation of SBM-R in Kab. Bireun and Kab. Serang, lessons learn for scaling up the program and replication to other districts have identified as follows:
   a. Alignment of program with national policy from the MOH to ensure the activities implemented in district are in accordance and have legal aspect from the government.
   b. Program implementation need to be engaged with planning unit for assuring the importance of the program, because some programs can have same objectives and need to be integrated.
   c. Commitment from the related sectors from village, sub district level, and DHO as implementer and supervisors. The commitment should emphasize that SBM-R is a process to improve performance and not just practical goal e.g. achieve score 100%.
   d. Implementation of SBM-R needs to begin with coordination to related key stakeholders and agreed upon the role in implementation. Furthermore the implementation also required guideline on the process and instruments to improve service quality.
   e. For scaling up the process efficiency can be made by utilizing existing program i.e. technical assistance and regional supervision for supervision.
   f. Monitoring and supervision are key elements for ensuring the progress of program and need to be outlined as routine activity.

2. General issues that need further discussion on the SBM-R implementation process are as:
   a. Overcome the limitation on procurement of equipment and consumable products as well as its maintenance in accordance to SBM-R standard for facility at all level particularly without donor supports
   b. One of the key points that determine the success of SBM-R implementation is supervision that should be conducted in routine and hierarchical manner. In conducting the supervision, strategies and mechanism need to be developed to ensure the sustainability of SBM-R in the future.
   c. Other important elements that can be either supporting or constraining the implementation of SBM-R are such as leadership, behavior, acceptance and commitment of health provider at level.

3. For sustainability and institutionalization of SBM-R several factors are required at each level as the following:
   a. DHO
      - Commitment to accept SBM-R as process to improve service performance of health provider and understand its role to monitor and supervise implementation
      - Collaboration across programs at DHO level to integrate SBM-R activities with other related programs e.g. nutrition, immunization, etc.
      - Based on the identified gaps during SBM-R implementation, develop plan for future activities to improve the implementation e.g. procurement of required equipment and its maintenance, conduct training and refreshing training, etc.

- Considering budget limitation, implementation SBM-R to PHC and village level could be done gradually i.e. determine selection criteria for facilities

b. PHC
   - Commitment of all staffs to accept SBM-R as process to improve service performance of health provider and understand its role to implement and routinely supervise SBM-R implementation at village level
   - Leadership of the head of PHC to support SBM-R and capacity to mobilize resource to support program implementation e.g. fulfillment of required equipment and products
   - Recognition mechanism for staffs' improvement in performing good quality of services

c. Hospital
   - Leadership and commitment from the Director, management, chief of ward, and service providers.
   - Coordination of all related units to integrate the program and ensure SBM-R process e.g. medical committee, functional management staff
   - Appropriate entry point (specific unit in the hospital) for program initiation and implementation
   - Conduct routine monitoring and evaluation, internal and external, of SBM-R and provide periodic refreshing training for staffs
   - Recognition mechanism for staffs' improvement in performing good quality of services

4. Input on the program and method and tools for SBM-R evaluation process are including:
   a. Tool:
      - Separation of tools adjusted with implementation of SBM-R at related wards
      - Tools need to be adjusted with existing standard operation procedure implemented in the hospital or facility. Adjustment can be made through consultation with medical committee at the facility.
      - Tool need to be added with column for respond "Not applicable" for the steps that never conducted at the facility. However this adjustment should not limited the facility to improve its quality by filling out the steps in consecutive manner.
      - To avoid missed interpretation of indicators and steps in SBM-R tool, guideline is needed for comprehensive explanation of the indicators e.g. definition, measurement, obligatory or optional.

   b. Method:
      - Evaluation of the process can be done by observing the tool filled in by health provider and observing the service provision to the patients and verified their skills
      - Show the video record of SBM-R implementation for certain services to help health provider understand the steps visually and can be used for refreshing
      - Supervision and evaluation should be conducted routinely with appropriate feedback for improving the service quality and performance.
      - At the beginning of implementation health providers and facility need to be trained on conducting the assessment, calculate score and produce output in form of graphics, tables, etc.
      - Ensure health provider keep the record on each cycles of assessment in order to see the progress of improvement.

Annex 4. Newspaper Publication on MCHIP Activities

KALTIM POST RABU, 26 SEPTEMBER 2012 43

DKK Balikpapan-MCHIP Gelar Lokakarya DTPS-KIBBLA

Januari-Agustus; 34 Bayi dan 6 Ibu Meninggal

BALIKPAPAN– Sebagai tindak lanjut kegiatan Mini University (MU) yang diselenggarakan Pemprov Kaltim pada 24-25 Mei 2012 lalu di Samarinda, Dinas Kesehatan Kota (DKK) Balikpapan bekerja sama dengan Material and Child Health Integrated Program (MCHIP) menyelenggarakan Orientasi Multipihak dan Lokakarya District Team Problem Solving (DTPS) Kesehatan Ibu, Bayi Baru Lahir dan Anak Balita (KIBBLA), Selasa (25/9) di Hotel Grand Tiga Mustika.

Lokakarya menghadirkan Dr Salkar dari MCHIP, Sutri Cahyono Dinkes Provinsi Kaltim, Misrun anggota Komisi IV DPRD Balikpapan, Kepala DKK Balikpapan Drg Dyah Muryani, Ibu Suhandi dari PKK Pokja IV dan dr Theresia Diskes Kutai Timur.

Menurut Dyah, MCHIP ini merupakan program dukungan United State Agency International Development (USAID) di 3 kabupaten dan 3 provinsi di Indonesia dengan fokus bantuan teknis program KIBBLA untuk mempercepat target Millenium Development Goals (MDGs) 2015, yakni menurunkan angka kematian ibu (AKI) dan angka kematian bayi (AKB). "Salah satu program teknis yang dilaksanakan adalah penguatan proses perencanaan DTPS-KIBBLA. Yang prosesnya menggunakan pendekatan partisipatif bersama stake holder untuk menyusun rencana usulan kegiatan yang terpilih dan berdampak percepatan terhadap penurunan AKI dan AKB," ujarnya.

Di Balikpapan, kata dia, sejak tahun 2009 hingga 2012 angka kematian ibu dan bayi terus meningkat (lihat boks).

Penyebabnya, kata Dyah, untuk kondisi Balikpapan secara garis besar ada dua hal; terlambat dirujuk oleh puskesmas atau bidan praktik swasta dan terlambat penanganan rumah sakit. Terlambat dirujuk ini bisa karena menunggu kepastian keluarga, karena pertimbangan biaya, menunggu transportasi, karena bidan dan dokter terlambat mendeteksi kondisi komplikasi maternal atau karena dokter atau bidan mencoba-coba menangani walaupun di luar kompetensinya.

KEJAR TARGET: Dyah (ketiga kanan) pada lokakarya DTPS-KIBBLA.

Untuk keterlambatan penanganan rumah sakit, tambahnya, hal ini dikarenakan sistem administrasi, walaupun sudah ada Jamkesda dan Jampersal tetapi pemahaman tentang juknisnya masih belum sama, sehingga terkesan administrasinya sulit. Bisa juga karena kekurangan tenaga dokter spesialis sehingga pasien menunggu, kekurangan sarana, antara lain belum tersedia bank darah di rumah sakit dan belum tersedianya ruang NICU di semua rumah sakit.

Dengan program tersebut, Dyah berharap, perencanaan yang disusun akan mudah dipahami dan diterima oleh semua pihak terutama legislatif yang dikuatkan dalam Perda APBD setiap tahunnya. "Untuk menjamin agar KIBBLA yang bermutu dapat berkelanjutan diperlukan Perda sebagai landasan hukum, yakni dalam bentuk Perda KIBBLA," kata Dyah. "Nah, dari kegiatan ini, selanjutnya dibentuk dan disusun tim perencanaan, tim advokasi dan fasilitator," lanjutnya.

Sementara Jamhur Ramli, District Program Manager MCHIP mengatakan, upaya untuk menurunkan angka kematian ibu dan bayi baru lahir harus melalui jalan yang terjal. Terlebih kala itu, dikaitkan dengan target MDGs 2015, yakni menurunkan angka kematian ibu AKI menjadi 102 per 100.000 kelahiran, hidup, dan angka kematian bayi (AKB) menjadi 23 per 100.000 kelahiran hidup yang harus dicapai. "Waktu yang tersisa hanya tinggal tiga tahun ini, tidak akan cukup untuk mencapai sasaran itu tanpa upaya-upaya yang luar biasa dari seluruh stake holder," katanya. **(ara/sos/dwa)**

RADAR TARAKAN JUMAT 21 SEPTEMBER 2012

2015, Target 80

TANJUNG SELOR – Kepala Dinas Kesehatan Kabupaten Bulungan, Idewan Budi Santoso mengungkapkan pembangunan kesehatan juga tidak terlepas dari komitmen Indonesia sebagai warga masyarakat dunia untuk ikut merealisasikan tercapainya Millenium Development Goals (MDGs) 2015, dan kesehatan dapat dikatakan sebagai unsur yang dominan.

Karena kelima dari delapan tujuan tersebut berkaitan langsung dengan kesehatan, yaitu tujuan pertama pemberantasan kemiskinan dan kelaparan, tujuan keempat menurunkan angka kematian anak, tujuan kelima meningkatkan kesehatan ibu, dan tujuan keenam memerangi HIV AIDS, malaria, TB dan penyakit lainnya serta tujuan ketujuh melestarikan lingkungan hidup.

"Pembangunan kesehatan merupakan tanggungjawab kita semua. Salah satu upaya percepatan pencapaian tujuan tersebut dilakukan dengan mengembangkan kesiapsiagaan di tingkat desa yang disebut Desa Siaga. Desa dan Kelurahan Siaga Aktif merupakan bentuk pengembangan dari Desa Siaga yang telah dimulai sejak 2006," ungkap Budi ketika membuka Lokakarya Kader Penggerak Desa Siaga yang dilaksanakan Dinas Kesehatan Bulungan bekerjasama dengan fasilitator Maternal and Child Health Integrated Program (MCHIP) Kutai Timur di gedung serbaguna eks kantor bupati, kemarin (20/9).

"Disebut Desa dan Kelurahan Siaga Aktif, karena penduduknya sudah mudah mengakses layanan kesehatan dasar, mengembangkan UKBM (Upaya Kesehatan Bersumberdaya Masyarakat) dan melaksanakan survailens berbasis masyarakat yang meliputi pengamatan penyakit, KIA (Kesehatan Ibu dan Anak), gizi, lingkungan dan prilaku, kedaruratan kesehatan, penyehatan lingkungan serta menerapkan PHBS (Pola Hidup Bersih dan Sehat). Dan program ini merupakan upaya yang strategis dalam percepatan pencapaian tujuan MDGs," jelas Budi.

Budi menambahkan, sejak dicanangkan tahun 2007 di Bulungan, pada tahun 2008 telah terbentuk 100 persen Desa Siaga. Namun, dari hasil laporan tahun 2011, menurut pedoman Desa Siaga Aktif tahun 2010 hanya sekira 59 persen.

Dimana permasalahannya pada pengurus Desa Siaga yang sebagian besar tidak aktif lagi. Untuk itu, pria yang sempat menjabat Direktur Rumah Sakit dr H Soemarno Soerpoatmodjo ini berharap perlu dilakukannya revitalisasi Desa

Persen Desa Siaga Aktif

SOFIAN HADI / RADAR TARAKAN

DILATIH : Dedi, salah satu fasilitator dari MCHIP Kutim ketika memberikan pelatihan kemarin (20/9).

Siaga guna mengakselerasi pencapaian target 80 persen Desa Siaga Aktif di tahun 2015.

"Oleh karena itu, berbagai upaya telah dilakukan Pemerintah Kabupaten Bulungan, dalam hal ini Dinas Kesehatan seperti penempatan tenaga bidan di setiap desa, membangun sarana kesehatan atau Pustu (Puskesmas Pembantu), melengkapi sarana Puskesmas (Pusat Kesehatan Masyarakat)

mengembangkan model atau percontohan Desa dan Kelurahan Siaga Aktif, melakukan workshop, pelatihan fasilitator dan evaluasi Desa Siaga Award dan lokakarya ini," tutur Budi kepada peserta lokakarya yang terdiri dari kader Desa Siaga, kader Posyandu, petugas Puskesmas, Tim Penggerak PKK (Pemberdayaan Kesehjateraan Keluarga) Lurah dan kepala desa dari lima desa

di Tanjung Selor dan Tanjung Palas ini.

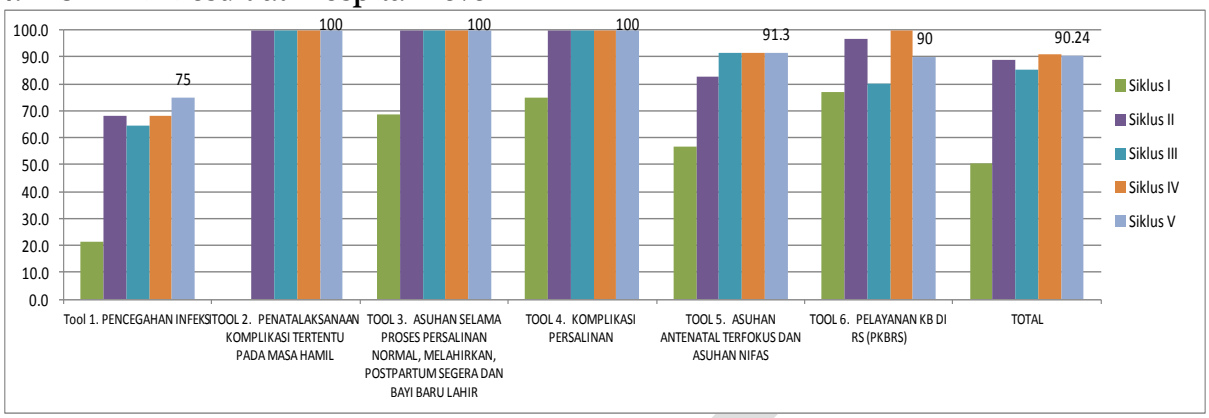
Sementara itu, ketua panitia Ida Bagus K Sidahardja mengatakan, kegiatan lokakarya ini adalah bentuk implementasi program KIBBLA (Kesehatan Ibu, Bayi Baru Lahir dan Anak) Terpadu bagi kabupaten dan kota yang ada di Kalimantan Timur, USAID-MCHIP dengan pendampingan dari Dinas Kesehatan Provinsi Kalimantan Timur telah melaksanakan pelatihan fasilitator Desa Siaga yang dilaksanakan pada tanggal 6 hingga 11 Agustus lalu di Samarinda.

Selain itu, dalam lokakarya ini juga akan dibentuk Forum Penggerak Desa Siaga yang nantinya akan menjadi percontohan bagi kecamatan-kecamatan lainnya di Bulungan. "Lokakarya ini bertujuan untuk memberikan pengetahuan dan keterampilan bagi masyarakat yang telah dipilih sebagai kader Penggerak Desa Siaga Aktif di tingkat kecamatan dalam hal pengelolaan dan pelaksanaan Desa Siaga Aktif di desanya masing-masing," terang Bagus dalam sambutannya.

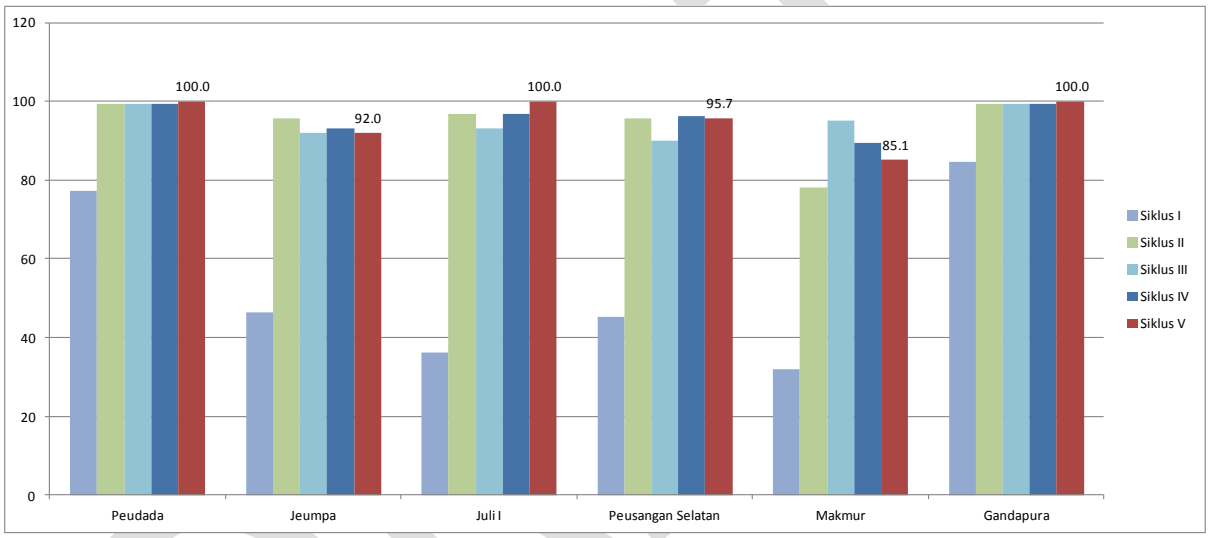
Untuk diketahui, dalam lokakarya yang berlangsung selama tiga hari ini akan diisi materi pelatihan dari tiga fasilitator dari MCHIP dan lima fasilitator lokal yang sebelumnya juga sudah ikut pelatihan di Samarinda. (sho/ndu)

Annex 5. SBM-R Result in Bireuen District

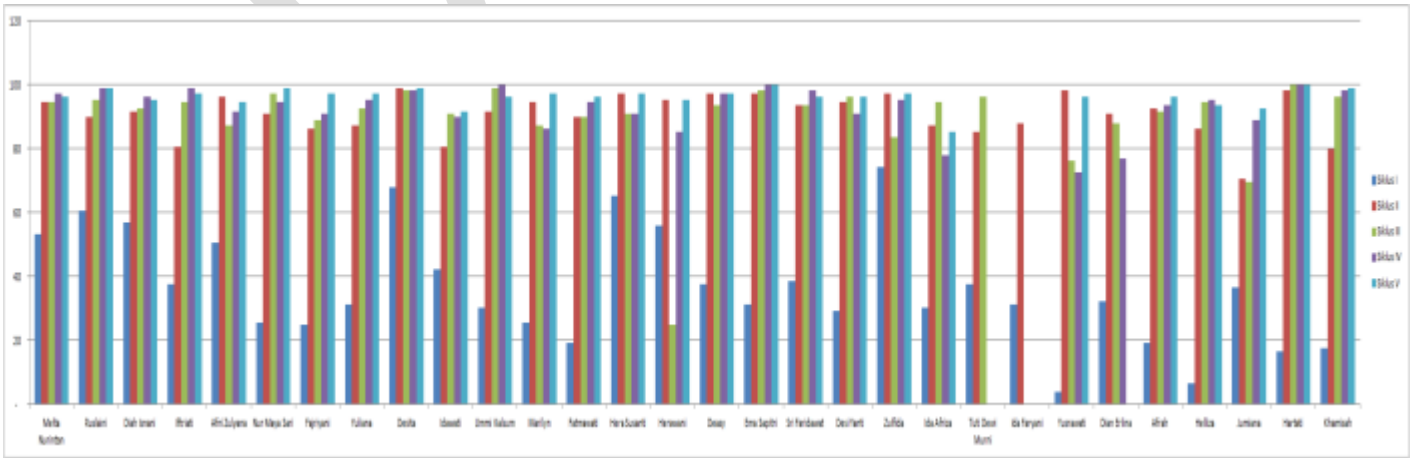
4.1 SBM-R Result at Hospital Level



4.2 SBM-R Result at Puskesmas Level

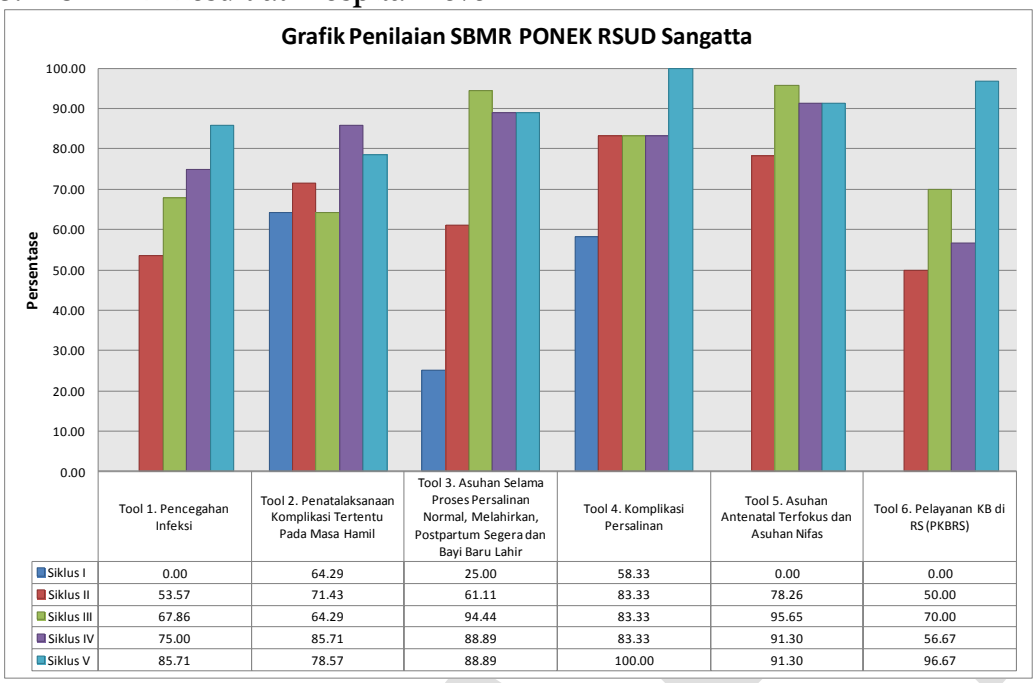


4.3 SBM-R Result at Midwife Level



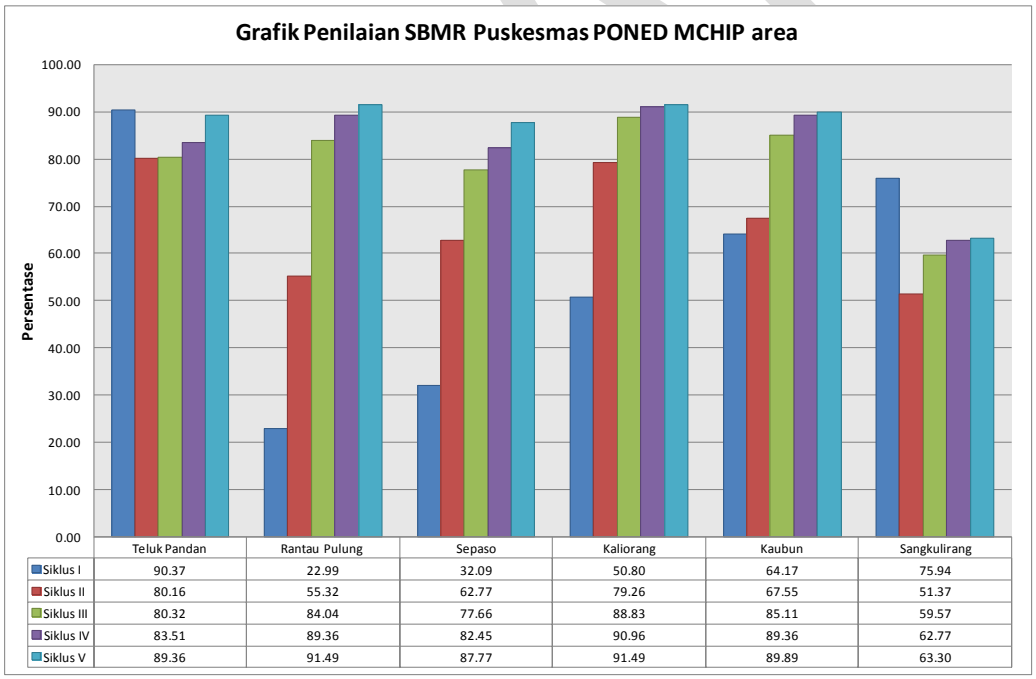
Annex 6. SBM-R Result in Kutai Timur District

5.1 SBM-R Result at Hospital Level



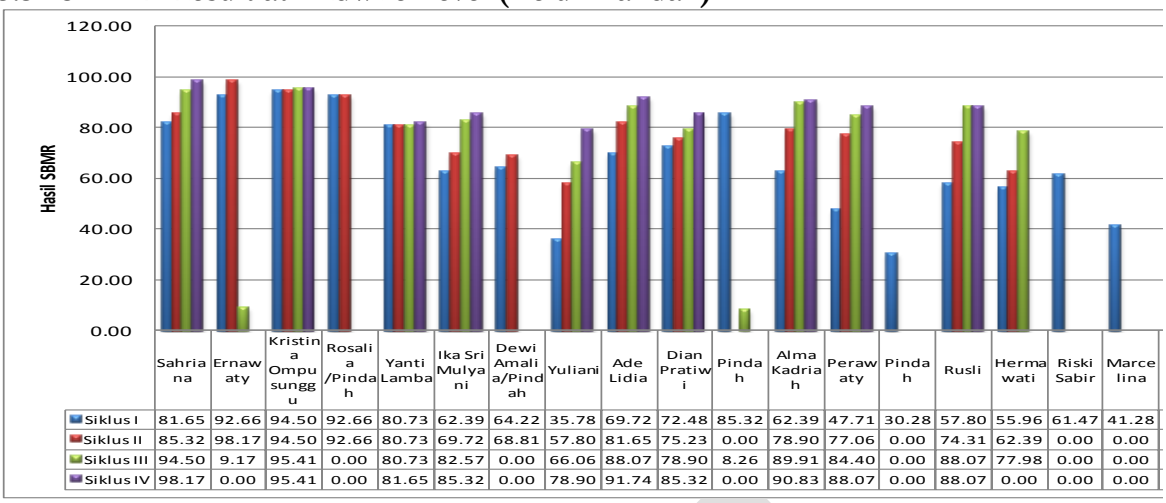
	Tool 1. Pencegahan Infeksi	Tool 2. Penatalaksanaan Komplikasi Tertentu Pada Masa Hamil	Tool 3. Asuhan Selama Proses Persalinan Normal, Melahirkan, Postpartum Segera dan Bayi Baru Lahir	Tool 4. Komplikasi Persalinan	Tool 5. Asuhan Antenatal Terfokus dan Asuhan Nifas	Tool 6. Pelayanan KB di RS (PKBRS)
Siklus I	0.00	64.29	25.00	58.33	0.00	0.00
Siklus II	53.57	71.43	61.11	83.33	78.26	50.00
Siklus III	67.86	64.29	94.44	83.33	95.65	70.00
Siklus IV	75.00	85.71	88.89	83.33	91.30	56.67
Siklus V	85.71	78.57	88.89	100.00	91.30	96.67

5.2 SBM-R Result at Puskesmas Level



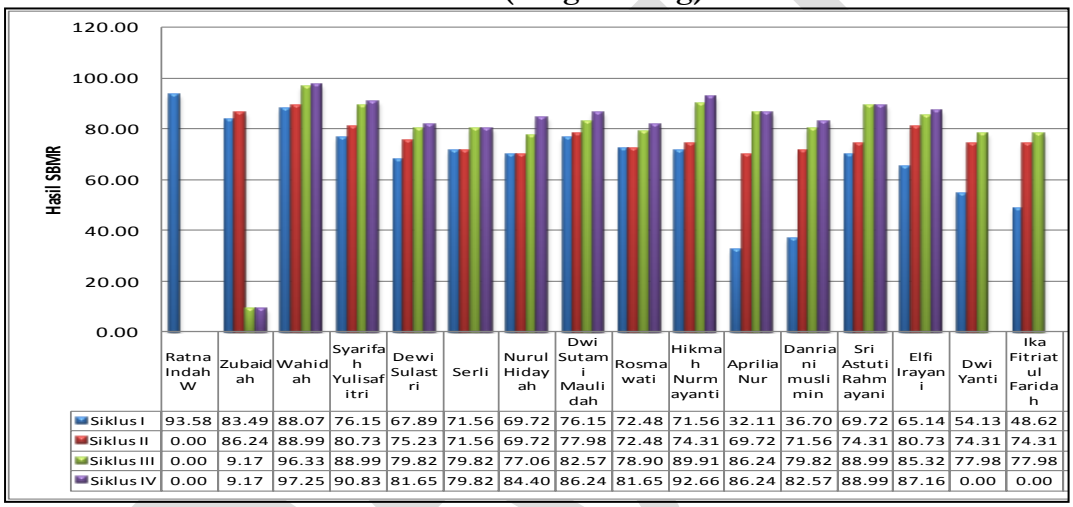
	Teluk Pandan	Rantau Pulung	Sepaso	Kaliorang	Kaubun	Sangkulirang
Siklus I	90.37	22.99	32.09	50.80	64.17	75.94
Siklus II	80.16	55.32	62.77	79.26	67.55	51.37
Siklus III	80.32	84.04	77.66	88.83	85.11	59.57
Siklus IV	83.51	89.36	82.45	90.96	89.36	62.77
Siklus V	89.36	91.49	87.77	91.49	89.89	63.30

5.3 SBM-R Result at Midwife Level (Teluk Pandan)



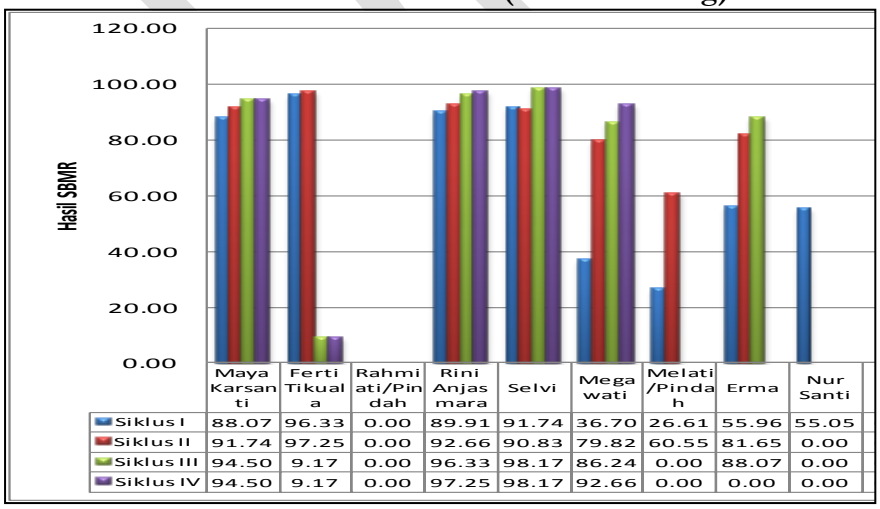
	Sahrina	Ernawaty	Kristina Ompusunggu	Rosalia /Pindah	Yanti Lamba	Ika Sri Mulyani	Dewi Amalia/Pindah	Yuliani	Ade Lidia	Dian Pratiwi	Pindah	Alma Kadriah	Perawaty	Pindah	Rusli	Hermawati	Riski Sabir	Marcelina
Siklus I	81.65	92.66	94.50	92.66	80.73	62.39	64.22	35.78	69.72	72.48	85.32	62.39	47.71	30.28	57.80	55.96	61.47	41.28
Siklus II	85.32	98.17	94.50	92.66	80.73	69.72	68.81	57.80	81.65	75.23	0.00	78.90	77.06	0.00	74.31	62.39	0.00	0.00
Siklus III	94.50	9.17	95.41	0.00	80.73	82.57	0.00	66.06	88.07	78.90	8.26	89.91	84.40	0.00	88.07	77.98	0.00	0.00
Siklus IV	98.17	0.00	95.41	0.00	81.65	85.32	0.00	78.90	91.74	85.32	0.00	90.83	88.07	0.00	88.07	0.00	0.00	0.00

5.4 SBM-R Result at Midwife Level (Sangkulirang)



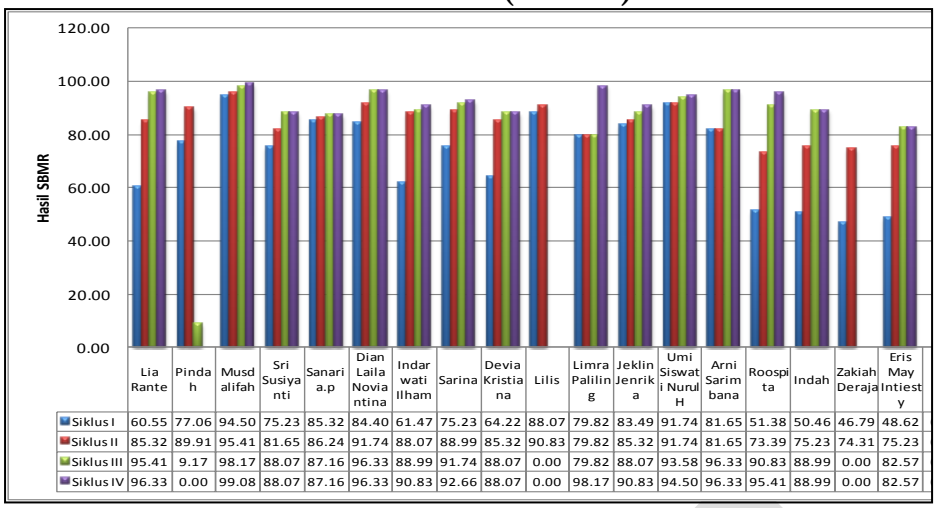
	Ratna Indah W	Zubaidah	Wahidah	Syarifah Yulisafitri	Dewi Sulastri	Serli	Nurul Hidayah	Dwi Sutami Maulidah	Rosmawati	Hikmah Nurmayanti	Aprilia Nur	Danriani muslimin	Sri Astuti Rahmayani	Elfi Irayani	Dwi Yanti	Ika Fitriatul Faridah
Siklus I	93.58	83.49	88.07	76.15	67.89	71.56	69.72	76.15	72.48	71.56	32.11	36.70	69.72	65.14	54.13	48.62
Siklus II	0.00	86.24	88.99	80.73	75.23	71.56	69.72	77.98	72.48	74.31	69.72	71.56	74.31	80.73	74.31	74.31
Siklus III	0.00	9.17	96.33	88.99	79.82	79.82	77.06	82.57	78.90	89.91	86.24	79.82	88.99	85.32	77.98	77.98
Siklus IV	0.00	9.17	97.25	90.83	81.65	79.82	84.40	86.24	81.65	92.66	86.24	82.57	88.99	87.16	0.00	0.00

5.5 SBM-R Result at Midwife Level (Rantau Pulung)



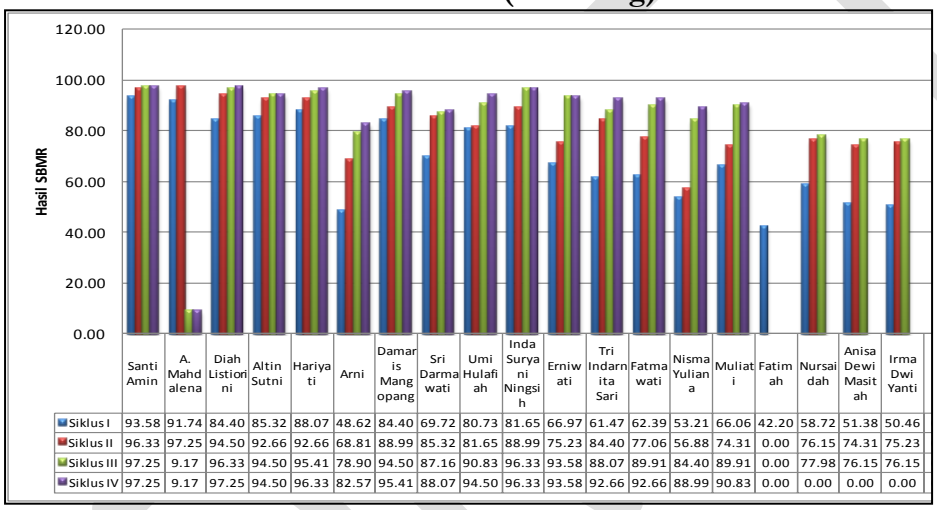
	Maya Karsanti	Fertikualia	Rahmiati/Pindah	Rini Anjasmara	Selvi	Megawati	Melati /Pindah	Erma	Nur Santi
Siklus I	88.07	96.33	0.00	89.91	91.74	36.70	26.61	55.96	55.05
Siklus II	91.74	97.25	0.00	92.66	90.83	79.82	60.55	81.65	0.00
Siklus III	94.50	9.17	0.00	96.33	98.17	86.24	0.00	88.07	0.00
Siklus IV	94.50	9.17	0.00	97.25	98.17	92.66	0.00	0.00	0.00

5.6 SBM-R Result at Midwife Level (Kaubun)



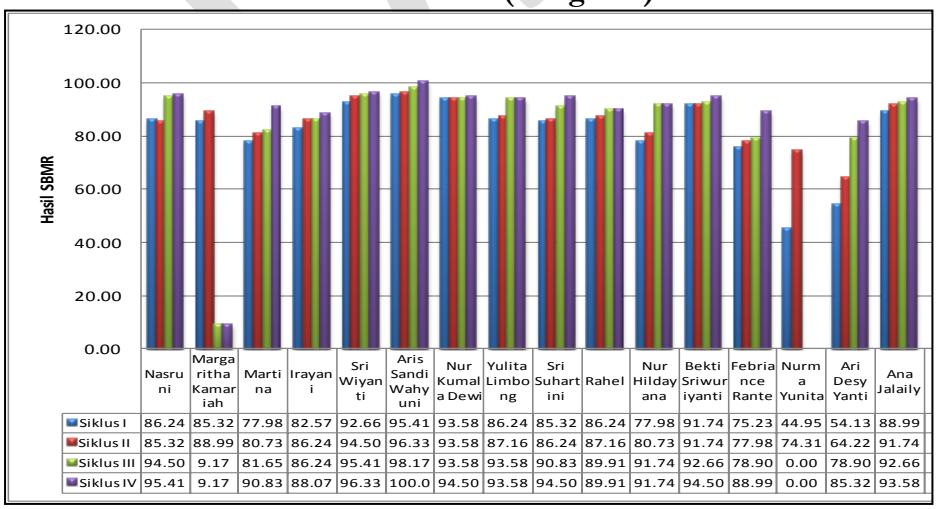
	Lia Rante	Pinda h	Musd alifah	Sri Susiya nti	Sanari a.p	Dian Laila Novia ntina	Indar wati Ilham	Sarina	Devia Kristia na	Lilis	Limra Palilin g	Jeklin Jenrik a	Umi Siswat i Nurul H	Arni Sarim bana	Roospi ta	Indah	Zakiah Deraja	Eris May Intiest y
Siklus I	60.55	77.06	94.50	75.23	85.32	84.40	61.47	75.23	64.22	88.07	79.82	83.49	91.74	81.65	51.38	50.46	46.79	48.62
Siklus II	85.32	89.91	95.41	81.65	86.24	91.74	88.07	88.99	85.32	90.83	79.82	85.32	91.74	81.65	73.39	75.23	74.31	75.23
Siklus III	95.41	9.17	98.17	88.07	87.16	96.33	88.99	91.74	88.07	0.00	79.82	88.07	93.58	96.33	90.83	88.99	0.00	82.57
Siklus IV	96.33	0.00	99.08	88.07	87.16	96.33	90.83	92.66	88.07	0.00	98.17	90.83	94.50	96.33	95.41	88.99	0.00	82.57

5.7 SBM-R Result at Midwife Level (Kaliorang)



	Santi Amin	A. Mahd alena	Diah Listiori ni	Altin Sutni	Hariya ti	Arni	Damar is Mang opang	Sri Darma wati	Umi Hulafi ah	Inda Surya ni Ningsi h	Erniw ati	Tri Indarn ita Sari	Fatma wati	Nisma Yulian a	Muliat i	Fatim ah	Nursai dah	Anisa Dewi Masit ah	Irma Dwi Yanti
Siklus I	93.58	91.74	84.40	85.32	88.07	48.62	84.40	69.72	80.73	81.65	66.97	61.47	62.39	53.21	66.06	42.20	58.72	51.38	50.46
Siklus II	96.33	97.25	94.50	92.66	92.66	68.81	88.99	85.32	81.65	88.99	75.23	84.40	77.06	56.88	74.31	0.00	76.15	74.31	75.23
Siklus III	97.25	9.17	96.33	94.50	95.41	78.90	94.50	87.16	90.83	96.33	93.58	88.07	89.91	84.40	89.91	0.00	77.98	76.15	76.15
Siklus IV	97.25	9.17	97.25	94.50	96.33	82.57	95.41	88.07	94.50	96.33	93.58	92.66	92.66	88.99	90.83	0.00	0.00	0.00	0.00

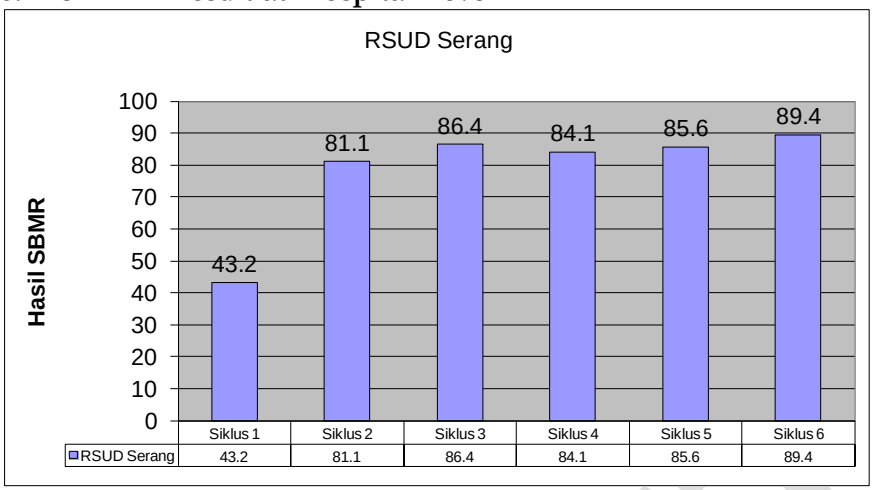
5.8 SBM-R Result at Midwife Level (Bengalon)



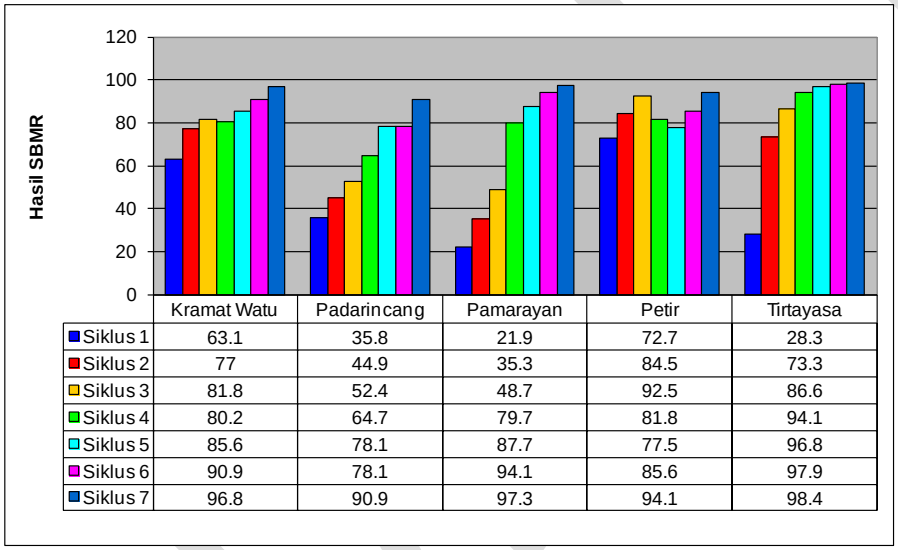
	Nasru ni	Marga ritha Kamar iah	Marti na	Irayan i	Sri Wiyan ti	Aris Sandi Wahy uni	Nur Kumal a Dewi	Yulita Limbo ng	Sri Suhart ini	Rahel	Nur Hilday ana	Bekti Sriwur iyanti	Febria nce Rante	Nurm a Yunita	Ari Desy Yanti	Ana Jalaily
Siklus I	86.24	85.32	77.98	82.57	92.66	95.41	93.58	86.24	85.32	86.24	77.98	91.74	75.23	44.95	54.13	88.99
Siklus II	85.32	88.99	80.73	86.24	94.50	96.33	93.58	87.16	86.24	87.16	80.73	91.74	77.98	74.31	64.22	91.74
Siklus III	94.50	9.17	81.65	86.24	95.41	98.17	93.58	93.58	90.83	89.91	91.74	92.66	78.90	0.00	78.90	92.66
Siklus IV	95.41	9.17	90.83	88.07	96.33	100.0	94.50	93.58	94.50	89.91	91.74	94.50	88.99	0.00	85.32	93.58

Annex 7. SBM-R Result in Serang District

6.1 SBM-R Result at Hospital Level

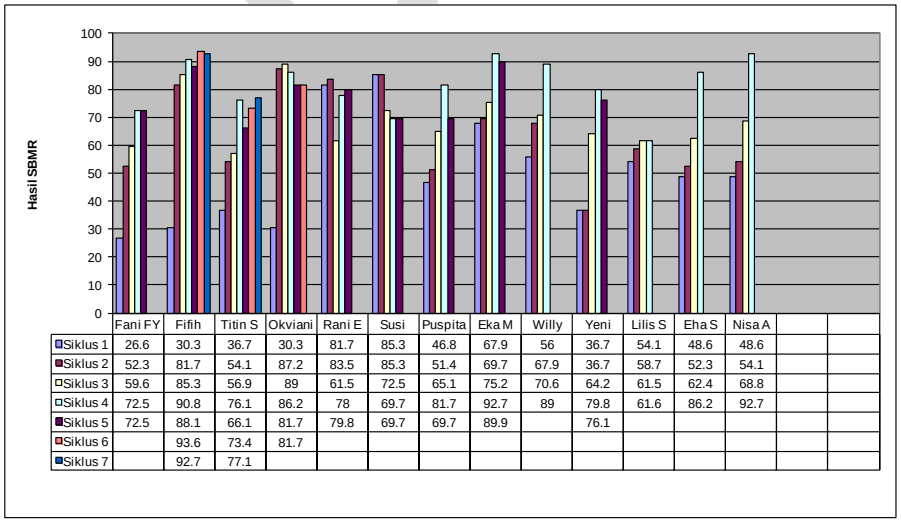


6.2 SBM-R Result at Puskesmas Level



	Kramat Watu	Padarincang	Pamarayan	Petir	Tirtayasa
Siklus 1	63.1	35.8	21.9	72.7	28.3
Siklus 2	77	44.9	35.3	84.5	73.3
Siklus 3	81.8	52.4	48.7	92.5	86.6
Siklus 4	80.2	64.7	79.7	81.8	94.1
Siklus 5	85.6	78.1	87.7	77.5	96.8
Siklus 6	90.9	78.1	94.1	85.6	97.9
Siklus 7	96.8	90.9	97.3	94.1	98.4

6.3 SBM-R Result at Midwife Level



	Fani FY	Fifih	Titin S	Okviani	Rani E	Susi	Puspita	Eka M	Willy	Yeni	Lilis S	Eha S	Nisa A		
Siklus 1	26.6	30.3	36.7	30.3	81.7	85.3	46.8	67.9	56	36.7	54.1	48.6	48.6		
Siklus 2	52.3	81.7	54.1	87.2	83.5	85.3	51.4	69.7	67.9	36.7	58.7	52.3	54.1		
Siklus 3	59.6	85.3	56.9	89	61.5	72.5	65.1	75.2	70.6	64.2	61.5	62.4	68.8		
Siklus 4	72.5	90.8	76.1	86.2	78	69.7	81.7	92.7	89	79.8	61.6	86.2	92.7		
Siklus 5	72.5	88.1	66.1	81.7	79.8	69.7	69.7	89.9		76.1					
Siklus 6		93.6	73.4	81.7											
Siklus 7		92.7	77.1												